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: 11-28-2012 TIME: 18:16_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST ANTHONY HOSPTAL (14-0095) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED 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		414,292	238,913			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		414,292	238,913			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: 2875 W. 19TH STREET	P.O.BOX:		1
2	CITY: CHICAGO STATE: IL	ZIP CODE: 60623	COUNTY: COOK	2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ST ANTHONY HOSPTAL	14-0095	16974	1	07/01/1967	N	P	P	3
4	SUBPROVIDER - IPF	PSYCHIATRIC UNIT	14-S095	16974	4	11/01/1988	N	P	P	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: 07/01/2011	TO: 06/30/2012							20
21	TYPE OF CONTROL		1							21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	11,607	1,710					24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			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

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

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

		1	2	3	
TEACHING HOSPITALS					
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	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, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

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

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

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

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

INPATIENT REHABILITATION FACILITY PPS

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

LONG TERM CARE HOSPITAL PPS

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

TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	86

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

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

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

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

MISCELLANEOUS COST REPORTING INFORMATION

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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE:		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N		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:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 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)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	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 0	COUNTY 1	STATE 2	ZIP CODE 3	CBSA 4	FTE/CAMPUS 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		169

(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

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

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N 1	TYPE 2	DATE 3	
	FINANCIAL DATA AND REPORTS				
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	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.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/19/2012	Y	10/19/2012	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

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

		Y/N	DATE	
		1	2	
	HOME OFFICE COSTS			
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.	N		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

	COST REPORT PREPARER CONTACT INFORMATION			
41	FIRST NAME:	LAST NAME:	TITLE:	41
42	EMPLOYER:			42
43	PHONE NUMBER:	E-MAIL ADDRESS:		43

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

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	94	34,404			5,845	7,858	15,556	1
2	HMO									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									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.)		94	34,404			5,845	7,858	15,556	7
8	INTENSIVE CARE UNIT	31	15	5,490			1,236	1,758	3,513	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						3,248	3,781	13
14	TOTAL (SEE INSTRUCTIONS)		109	39,894			7,081	12,864	22,850	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	42	15,372			3,186	4,863	9,927	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)		151							27
28	OBSERVATION BED DAYS								55	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)							453	1,057	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					1,210	4,560	8,943	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)		1.78	713.08			1,210	4,560	8,943	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		34.61			289	655	1,186	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)		1.78	747.69						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	46,764,974		46,764,974	1,534,890.00	30.47	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING		829,683		829,683	8,494.00	97.68	4.01
5	PHYSICIAN-PART B		2,664,863		2,664,863	38,994.00	68.34	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,391,369		6,391,369	150,077.00	42.59	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		200,072		200,072	2,992.00	66.87	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		9,646,870	-1,241,706	8,405,164			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		943,242		943,242			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING		53,385					22.01
23	PHYSICIAN PART B		245,079		245,079			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS		562,348		562,348	17,645.00	31.87	26
27	ADMINISTRATIVE & GENERAL		6,972,586		6,972,586	339,917.00	20.51	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		658,459		658,459	3,819.00	172.42	28
29	MAINTENANCE & REPAIRS		362,229		362,229	17,397.00	20.82	29
30	OPERATION OF PLANT		484,151		484,151	28,982.00	16.71	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		863,586		863,586	108,147.00	7.99	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)		187,353		187,353	6,500.00	28.82	33
34	DIETARY		868,874	-443,126	425,748	39,385.00	10.81	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			443,126	443,126	40,992.00	10.81	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,064,521		1,064,521	51,852.00	20.53	38
39	CENTRAL SERVICES AND SUPPLY		308,872		308,872	27,442.00	11.26	39
40	PHARMACY		972,403		972,403	43,820.00	22.19	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		399,044		399,044	17,410.00	22.92	41
42	SOCIAL SERVICE		544,144		544,144	24,303.00	22.39	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	44,945,923		44,945,923	1,506,215.0	29.84	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,391,369		6,391,369	150,077.00	42.59	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	38,554,554		38,554,554	1,356,138.0	28.43	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	200,072		200,072	2,992.00	66.87	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	9,646,870	-1,241,706	8,405,164		21.80%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	48,401,496	-1,241,706	47,159,790	1,359,130.0	34.70	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	14,248,570		14,248,570	767,611.00	18.56	7

HOSPITAL WAGE RELATED COSTS — WORKSHEET S-3 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1,362,327	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		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)	4,075,218	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	179,108	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	59,069	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	133,377	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	3,328,948	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	223,335	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	285,488	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	9,646,870	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	48,723	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	194,740		1
2	HOSPITAL	193,681		2
3	SUBPROVIDER - IPF	1,059		3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.275811	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	33,167,259	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	122,722,062	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	33,848,095	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	680,836	8
	STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)		
9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12
	OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)		
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16
	UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)		
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	680,836	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	19,632,770	2,053,710	21,686,480	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	5,414,934	566,436	5,981,370	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	157,062	355,292	512,354	22
23	COST OF CHARITY CARE	5,257,872	211,144	5,469,016	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	7,246,655	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	1,085,100	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	6,161,555	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	1,699,425	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	7,168,441	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	7,849,277	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		2,297,554	2,297,554		1
2	00200	CAP REL COSTS-MVBLE EQUIP		339,221	339,221		2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	562,348	6,796,767	7,359,115		4
5.01	00540	COMMUNICATIONS					5.01
5.02	00561	PURCHASING, RECEIVING					5.02
5.03	00571	ADMITTING					5.03
5.04	00581	CASHERING/ACCOUNTS RECEIVABLE					5.04
5.05	00551	DATA PROCESSING					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	6,972,586	17,462,848	24,435,434		5.06
6	00600	MAINTENANCE & REPAIRS	362,229	1,223,530	1,585,759		6
7	00700	OPERATION OF PLANT	484,151	1,188,873	1,673,024		7
8	00800	LAUNDRY & LINEN SERVICE				507,001	8
9	00900	HOUSEKEEPING	863,586	1,049,568	1,913,154		9
10	01000	DIETARY	868,874	1,048,708	1,917,582	-977,967	10
11	01100	CAFETERIA				977,967	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	1,064,521	102,845	1,167,366		13
14	01400	CENTRAL SERVICES & SUPPLY	308,872	628,225	937,097	-507,001	14
15	01500	PHARMACY	972,403	3,996,917	4,969,320	-3,715,307	15
16	01600	MEDICAL RECORDS & LIBRARY	399,044	191,606	590,650		16
17	01700	SOCIAL SERVICE	544,144	80,198	624,342		17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	1,607,534	771,188	2,378,722		22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	5,896,798	869,805	6,766,603		30
31	03100	INTENSIVE CARE UNIT	2,021,617	337,597	2,359,214		31
40	04000	SUBPROVIDER - IPF	2,069,386	279,931	2,349,317		40
43	04300	NURSERY	1,261,887	119,886	1,381,773		43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	1,507,831	2,228,619	3,736,450	-75,557	50
51	05100	RECOVERY ROOM	318,846	35,630	354,476		51
52	05200	DELIVERY ROOM & LABOR ROOM	3,560,477	685,974	4,246,451		52
53	05300	ANESTHESIOLOGY		1,024,828	1,024,828		53
54	05400	RADIOLOGY-DIAGNOSTIC	2,225,225	925,979	3,151,204		54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	332,670	145,452	478,122		57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	129,360	31,528	160,888		58
60	06000	LABORATORY	1,582,069	1,409,759	2,991,828		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	32,971	572,081	605,052		63
65	06500	RESPIRATORY THERAPY	642,080	306,966	949,046		65
66	06600	PHYSICAL THERAPY	847,364	136,285	983,649		66
69	06900	ELECTROCARDIOLOGY	426,290	146,923	573,213		69
70	07000	ELECTROENCEPHALOGRAPHY	54,063	9,360	63,423		70
72	07200	IMPL. DEV. CHARGED TO PATIENT				75,557	72
73	07300	DRUGS CHARGED TO PATIENTS				3,715,307	73
75	07500	ASC (NON-DISTINCT PART)	299,215	42,293	341,508		75
76	03950	HEMODIALYSIS		343,705	343,705		76
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90	09000	CLINIC	1,659,826	555,108	2,214,934		90
91	09100	EMERGENCY	2,564,724	612,051	3,176,775		91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	42,442,991	47,997,808	90,440,799		118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,440	66,193	114,633		190
192	19200	PHYSICIANS' PRIVATE OFFICES	4,273,543	1,308,230	5,581,773		192
192.01	19210	FUND DEVELOPMENT					192.01
200		TOTAL (SUM OF LINES 118-199)	46,764,974	49,372,231	96,137,205		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	2,297,554	2,268,072	4,565,626	1
2	00200	CAP REL COSTS-MVBLE EQUIP	339,221		339,221	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	7,359,115		7,359,115	4
5.01	00540	COMMUNICATIONS				5.01
5.02	00561	PURCHASING, RECEIVING				5.02
5.03	00571	ADMITTING				5.03
5.04	00581	CASHERING/ACCOUNTS RECEIVABLE				5.04
5.05	00551	DATA PROCESSING				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	24,435,434	-740,917	23,694,517	5.06
6	00600	MAINTENANCE & REPAIRS	1,585,759		1,585,759	6
7	00700	OPERATION OF PLANT	1,673,024	-18,200	1,654,824	7
8	00800	LAUNDRY & LINEN SERVICE	507,001		507,001	8
9	00900	HOUSEKEEPING	1,913,154		1,913,154	9
10	01000	DIETARY	939,615		939,615	10
11	01100	CAFETERIA	977,967	-524,211	453,756	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,167,366	-2,150	1,165,216	13
14	01400	CENTRAL SERVICES & SUPPLY	430,096	-91	430,005	14
15	01500	PHARMACY	1,254,013	-11,132	1,242,881	15
16	01600	MEDICAL RECORDS & LIBRARY	590,650	-936	589,714	16
17	01700	SOCIAL SERVICE	624,342		624,342	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	2,378,722	-1,154,158	1,224,564	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	6,766,603	-809,526	5,957,077	30
31	03100	INTENSIVE CARE UNIT	2,359,214		2,359,214	31
40	04000	SUBPROVIDER - IPF	2,349,317		2,349,317	40
43	04300	NURSERY	1,381,773	-455,034	926,739	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	3,660,893		3,660,893	50
51	05100	RECOVERY ROOM	354,476		354,476	51
52	05200	DELIVERY ROOM & LABOR ROOM	4,246,451	-925,132	3,321,319	52
53	05300	ANESTHESIOLOGY	1,024,828		1,024,828	53
54	05400	RADIOLOGY-DIAGNOSTIC	3,151,204	-600	3,150,604	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	478,122		478,122	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	160,888		160,888	58
60	06000	LABORATORY	2,991,828	-22,757	2,969,071	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	605,052		605,052	63
65	06500	RESPIRATORY THERAPY	949,046		949,046	65
66	06600	PHYSICAL THERAPY	983,649		983,649	66
69	06900	ELECTROCARDIOLOGY	573,213		573,213	69
70	07000	ELECTROENCEPHALOGRAPHY	63,423		63,423	70
72	07200	IMPL. DEV. CHARGED TO PATIENT	75,557		75,557	72
73	07300	DRUGS CHARGED TO PATIENTS	3,715,307		3,715,307	73
75	07500	ASC (NON-DISTINCT PART)	341,508		341,508	75
76	03950	HEMODIALYSIS	343,705		343,705	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90	09000	CLINIC	2,214,934	-319,655	1,895,279	90
91	09100	EMERGENCY	3,176,775		3,176,775	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	90,440,799	-2,716,427	87,724,372	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,633		114,633	190
192	19200	PHYSICIANS' PRIVATE OFFICES	5,581,773		5,581,773	192
192.01	19210	FUND DEVELOPMENT				192.01
200		TOTAL (SUM OF LINES 118-199)	96,137,205	-2,716,427	93,420,778	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA RECLASS	B	CAFETERIA	11	443,126	534,841	1
500	TOTAL RECLASSIFICATIONS				443,126	534,841	500
	CODE LETTER - B						
1	COST OF MEDICAL SUPPLIES	C	IMPL. DEV. CHARGED TO PATIENT	72		75,557	1
500	TOTAL RECLASSIFICATIONS					75,557	500
	CODE LETTER - C						
1	COST OF DRUGS SOLD	D	DRUGS CHARGED TO PATIENTS	73		3,715,307	1
500	TOTAL RECLASSIFICATIONS					3,715,307	500
	CODE LETTER - D						
1	RECLASS LAUNDRY COSTS	E	LAUNDRY & LINEN SERVICE	8		507,001	1
500	TOTAL RECLASSIFICATIONS					507,001	500
	CODE LETTER - E						
	GRAND TOTAL (INCREASES)				443,126	4,832,706	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	CAFETERIA RECLASS	B	DIETARY	10	443,126	534,841	1
500	TOTAL RECLASSIFICATIONS				443,126	534,841	500
	CODE LETTER - B						
1	COST OF MEDICAL SUPPLIES	C	OPERATING ROOM	50		75,557	1
500	TOTAL RECLASSIFICATIONS					75,557	500
	CODE LETTER - C						
1	COST OF DRUGS SOLD	D	PHARMACY	15		3,715,307	1
500	TOTAL RECLASSIFICATIONS					3,715,307	500
	CODE LETTER - D						
1	RECLASS LAUNDRY COSTS	E	CENTRAL SERVICES & SUPPLY	14		507,001	1
500	TOTAL RECLASSIFICATIONS					507,001	500
	CODE LETTER - E						
	GRAND TOTAL (DECREASES)				443,126	4,832,706	

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	472,850					472,850		1
2	LAND IMPROVEMENTS	330,859	161,314		161,314	124	492,049		2
3	BUILDINGS AND FIXTURES	24,081,925	617,200		617,200	763,654	23,935,471		3
4	BUILDING IMPROVEMENTS	1,961,591	453,271		453,271	534,870	1,879,992		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	27,162,784	8,389,353		8,389,353	5,633,121	29,919,016		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	54,010,009	9,621,138		9,621,138	6,931,769	56,699,378		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	54,010,009	9,621,138		9,621,138	6,931,769	56,699,378		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	2,297,554						2,297,554	1
2	CAP REL COSTS-MVBLE EQUIP	339,221						339,221	2
3	TOTAL (SUM OF LINES 1-2)	2,636,775						2,636,775	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									1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (SUM OF LINES 1-2)									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	4,565,626						4,565,626	1
2	CAP REL COSTS-MVBLE EQUIP	339,221						339,221	2
3	TOTAL	4,904,847						4,904,847	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,770,106				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-524,211	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-11,132	PHARMACY	15		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		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		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		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34							34
35	CAPITAL IMPAIRMENT AMORTIZATION	A	2,268,072	CAP REL COSTS-BLDG & FIXT	1	9	35
36	OTHER REVENUE	B	-553,710	ADMINISTRATIVE & GENERAL	5.06		36
36.01	OTHER REVENUE	B	-18,200	OPERATION OF PLANT	7		36.01
36.02	OTHER REVENUE	B	-2,150	NURSING ADMINISTRATION	13		36.02
36.03	OTHER REVENUE	B	-91	CENTRAL SERVICES & SUPPLY	14		36.03
36.04	OTHER REVENUE	B	-936	MEDICAL RECORDS & LIBRARY	16		36.04
36.08	OTHER REVENUE	B	-707,733	I&R SRVCES-OTHER PRGM COSTS APP	22		36.08
36.09	OTHER REVENUE	B	-1,355	ADULTS & PEDIATRICS	30		36.09
37	MILLENIUM BLDG 1ST FLOOR 33% GL	A	-187,207	ADMINISTRATIVE & GENERAL	5.06		37
38	OTHER REVENUE	B	-600	RADIOLOGY-DIAGNOSTIC	54		38
39	OTHER REVENUE	B	-22,757	LABORATORY	60		39
40	OTHER REVENUE	B	-184,311	CLINIC	90		40
41	OTHER REVENUE						41
42	OTHER REVENUE						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)		-2,716,427				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								1
2								2
3								3
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.						5

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	22	I&R SRVCES-OTHER PRGM CO	AGGREGATE	341,182	341,182						1
2	22	I&R SRVCES-OTHER PRGM CO	TEACHING PHYSIC	829,683		829,683	177,400	8,494	724,440	36,222	2
3	30	ADULTS & PEDIATRICS	AGGREGATE	808,171	808,171						3
4	43	NURSERY	AGGREGATE	455,034	455,034						4
5	52	DELIVERY ROOM & LABOR RO	AGGREGATE	925,132	925,132						5
6	90	CLINIC	AGGREGATE	135,344	135,344						6
200		TOTAL		3,494,546	2,664,863	829,683		8,494	724,440	36,222	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
1	22	I&R SRVCES-OTHER PRGM CO	AGGREGATE							341,182	1
2	22	I&R SRVCES-OTHER PRGM CO	TEACHING PHYSIC					724,440	105,243	105,243	2
3	30	ADULTS & PEDIATRICS	AGGREGATE							808,171	3
4	43	NURSERY	AGGREGATE							455,034	4
5	52	DELIVERY ROOM & LABOR RO	AGGREGATE							925,132	5
6	90	CLINIC	AGGREGATE							135,344	6
200		TOTAL						724,440	105,243	2,770,106	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	4,565,626	4,565,626				1
2	CAP REL COSTS-MVBLE EQUIP	339,221		339,221			2
4	EMPLOYEE BENEFITS	7,359,115	17,956	192	7,377,263		4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	23,694,517	563,224	18,380	1,113,323	25,389,444	5.06
6	MAINTENANCE & REPAIRS	1,585,759	170,612	5,656	57,838	1,819,865	6
7	OPERATION OF PLANT	1,654,824	562,953	30,627	77,305	2,325,709	7
8	LAUNDRY & LINEN SERVICE	507,001	79,595			586,596	8
9	HOUSEKEEPING	1,913,154	40,980	331	137,891	2,092,356	9
10	DIETARY	939,615	197,016	2,761	67,980	1,207,372	10
11	CAFETERIA	453,756			70,755	524,511	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,165,216	79,910	1,517	169,974	1,416,617	13
14	CENTRAL SERVICES & SUPPLY	430,005	117,826	4,048	49,318	601,197	14
15	PHARMACY	1,242,881	65,154	963	155,266	1,464,264	15
16	MEDICAL RECORDS & LIBRARY	589,714	83,244	1,339	63,716	738,013	16
17	SOCIAL SERVICE	624,342	22,484		86,885	733,711	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	1,224,564			256,678	1,481,242	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,957,077	949,480	7,801	941,554	7,855,912	30
31	INTENSIVE CARE UNIT	2,359,214	129,181	5,964	322,796	2,817,155	31
40	SUBPROVIDER - IPF	2,349,317	284,022	531	330,423	2,964,293	40
43	NURSERY	926,739	28,567	497	201,488	1,157,291	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,660,893	130,623	35,136	240,758	4,067,410	50
51	RECOVERY ROOM	354,476			50,911	405,387	51
52	DELIVERY ROOM & LABOR ROOM	3,321,319	87,480	5,986	568,508	3,983,293	52
53	ANESTHESIOLOGY	1,024,828	16,852	16		1,041,696	53
54	RADIOLOGY-DIAGNOSTIC	3,150,604	242,164	162,037	355,306	3,910,111	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	478,122			53,118	531,240	57
58	MAGNETIC RESONANCE IMAGING (MRI)	160,888			20,655	181,543	58
60	LABORATORY	2,969,071	160,609	20,767	252,612	3,403,059	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	605,052			5,265	610,317	63
65	RESPIRATORY THERAPY	949,046	29,581	5,570	102,522	1,086,719	65
66	PHYSICAL THERAPY	983,649	38,930	96	135,300	1,157,975	66
69	ELECTROCARDIOLOGY	573,213	22,574	2,087	68,067	665,941	69
70	ELECTROENCEPHALOGRAPHY	63,423	14,261	972	8,632	87,288	70
72	IMPL. DEV. CHARGED TO PATIENT	75,557				75,557	72
73	DRUGS CHARGED TO PATIENTS	3,715,307				3,715,307	73
75	ASC (NON-DISTINCT PART)	341,508			47,776	389,284	75
76	HEMODIALYSIS	343,705				343,705	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,895,279	136,120	19	265,028	2,296,446	90
91	EMERGENCY	3,176,775	83,695	6,758	409,515	3,676,743	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	87,724,372	4,355,093	320,051	6,687,163	86,804,569	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114,633	3,379	54	7,735	125,801	190
192	PHYSICIANS' PRIVATE OFFICES	5,581,773	207,154	19,116	682,365	6,490,408	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	93,420,778	4,565,626	339,221	7,377,263	93,420,778	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	A+G	MAINTEN-ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.06	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	25,389,444					5.06
6	MAINTENANCE & REPAIRS	679,177	2,499,042				6
7	OPERATION OF PLANT	867,959	368,879	3,562,547			7
8	LAUNDRY & LINEN SERVICE	218,919	52,155	87,226	944,896		8
9	HOUSEKEEPING	780,871	26,853	44,909		2,944,989	9
10	DIETARY	450,594	129,096	215,904			10
11	CAFETERIA	195,749					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	528,684	52,362	87,571			13
14	CENTRAL SERVICES & SUPPLY	224,368	77,207	129,123			14
15	PHARMACY	546,466	42,692	71,400			15
16	MEDICAL RECORDS & LIBRARY	275,428	54,547	91,225		17,689	16
17	SOCIAL SERVICE	273,822	14,733	24,639			17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	552,802				248,057	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,931,857	622,151	1,040,510	491,346	654,705	30
31	INTENSIVE CARE UNIT	1,051,368	84,647	141,566	94,490	130,266	31
40	SUBPROVIDER - IPF	1,106,280	186,108	311,252	255,123	254,294	40
43	NURSERY	431,903	18,719	31,305	103,937		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,517,966	85,592	143,146		284,458	50
51	RECOVERY ROOM	151,291					51
52	DELIVERY ROOM & LABOR ROOM	1,486,573	57,322	95,867		592,331	52
53	ANESTHESIOLOGY	388,763	11,042	18,467			53
54	RADIOLOGY-DIAGNOSTIC	1,459,261	158,679	265,380		261,350	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	198,260					57
58	MAGNETIC RESONANCE IMAGING (MRI)	67,752					58
60	LABORATORY	1,270,028	105,240	176,007		43,354	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	227,772					63
65	RESPIRATORY THERAPY	405,566	19,383	32,416		13,292	65
66	PHYSICAL THERAPY	432,159	25,509	42,662		19,939	66
69	ELECTROCARDIOLOGY	248,531	14,792	24,738		17,689	69
70	ELECTROENCEPHALOGRAPHY	32,576	9,345	15,628			70
72	IMPL. DEV. CHARGED TO PATIENT	28,198					72
73	DRUGS CHARGED TO PATIENTS	1,386,560				12,372	73
75	ASC (NON-DISTINCT PART)	145,282					75
76	HEMODIALYSIS	128,271					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	857,038	89,194	149,170		39,877	90
91	EMERGENCY	1,372,168	54,842	91,719		210,838	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	22,920,262	2,361,089	3,331,830	944,896	2,800,511	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,949	2,214	3,703		62,065	190
192	PHYSICIANS' PRIVATE OFFICES	2,422,233	135,739	227,014		82,413	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	25,389,444	2,499,042	3,562,547	944,896	2,944,989	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	2,002,966					10
11	CAFETERIA		720,260				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		38,235	2,123,469			13
14	CENTRAL SERVICES & SUPPLY		10,825		1,042,720		14
15	PHARMACY		17,291			2,142,113	15
16	MEDICAL RECORDS & LIBRARY		6,869				16
17	SOCIAL SERVICE		9,585				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		9,068	2,393			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,168,125	143,034	853,654			30
31	INTENSIVE CARE UNIT	230,299	38,571	236,282			31
40	SUBPROVIDER - IPF	604,542	57,480	169,214			40
43	NURSERY		17,488	93,981			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		24,481	93,893	1,042,720		50
51	RECOVERY ROOM		4,965	35,861			51
52	DELIVERY ROOM & LABOR ROOM		61,813	295,752			52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		45,506	6,900			54
57	COMPUTED TOMOGRAPHY (CT) SCAN		9,651				57
58	MAGNETIC RESONANCE IMAGING (MRI)		3,718				58
60	LABORATORY		42,371				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY		17,694				65
66	PHYSICAL THERAPY		9,405				66
69	ELECTROCARDIOLOGY		11,038				69
70	ELECTROENCEPHALOGRAPHY		1,141				70
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS					2,142,113	73
75	ASC (NON-DISTINCT PART)		3,480	18,734			75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		35,551	41,907			90
91	EMERGENCY		72,219	259,198			91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,002,966	691,479	2,107,769	1,042,720	2,142,113	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,740				190
192	PHYSICIANS' PRIVATE OFFICES		27,041	15,700			192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,002,966	720,260	2,123,469	1,042,720	2,142,113	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,183,771					16
17	SOCIAL SERVICE		1,056,490				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD			2,293,562			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	126,320	574,960	917,425	17,379,999	-917,425	30
31	INTENSIVE CARE UNIT	45,685	71,596		4,941,925		31
40	SUBPROVIDER - IPF	60,756	273,650		6,242,992		40
43	NURSERY	21,277	136,284		2,012,185		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	96,281			7,355,947		50
51	RECOVERY ROOM	5,949			603,453		51
52	DELIVERY ROOM & LABOR ROOM	49,163			6,622,114		52
53	ANESTHESIOLOGY	41,265			1,501,233		53
54	RADIOLOGY-DIAGNOSTIC	94,811			6,201,998		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	69,930			809,081		57
58	MAGNETIC RESONANCE IMAGING (MRI)	14,137			267,150		58
60	LABORATORY	100,198			5,140,257		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	14,119			852,208		63
65	RESPIRATORY THERAPY	45,496			1,620,566		65
66	PHYSICAL THERAPY	23,003			1,710,652		66
69	ELECTROCARDIOLOGY	25,499			1,008,228		69
70	ELECTROENCEPHALOGRAPHY	3,931			149,909		70
72	IMPL. DEV. CHARGED TO PATIENT	5,278			109,033		72
73	DRUGS CHARGED TO PATIENTS	151,309			7,407,661		73
75	ASC (NON-DISTINCT PART)	6,985			563,765		75
76	HEMODIALYSIS	4,502			476,478		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	29,698		458,712	3,997,593	-458,712	90
91	EMERGENCY	148,179		917,425	6,803,331	-917,425	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,183,771	1,056,490	2,293,562	83,777,758	-2,293,562	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				242,472		190
192	PHYSICIANS' PRIVATE OFFICES				9,400,548		192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,183,771	1,056,490	2,293,562	93,420,778	-2,293,562	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B, PART I

	COST CENTER DESCRIPTION	TOTAL (26)	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	16,462,574	30
31	INTENSIVE CARE UNIT	4,941,925	31
40	SUBPROVIDER - IPF	6,242,992	40
43	NURSERY	2,012,185	43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	7,355,947	50
51	RECOVERY ROOM	603,453	51
52	DELIVERY ROOM & LABOR ROOM	6,622,114	52
53	ANESTHESIOLOGY	1,501,233	53
54	RADIOLOGY-DIAGNOSTIC	6,201,998	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	809,081	57
58	MAGNETIC RESONANCE IMAGING (MRI)	267,150	58
60	LABORATORY	5,140,257	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	852,208	63
65	RESPIRATORY THERAPY	1,620,566	65
66	PHYSICAL THERAPY	1,710,652	66
69	ELECTROCARDIOLOGY	1,008,228	69
70	ELECTROENCEPHALOGRAPHY	149,909	70
72	IMPL. DEV. CHARGED TO PATIENT	109,033	72
73	DRUGS CHARGED TO PATIENTS	7,407,661	73
75	ASC (NON-DISTINCT PART)	563,765	75
76	HEMODIALYSIS	476,478	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	3,538,881	90
91	EMERGENCY	5,885,906	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	81,484,196	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	242,472	190
192	PHYSICIANS' PRIVATE OFFICES	9,400,548	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	91,127,216	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 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		17,956	192	18,148	18,148	4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL		563,224	18,380	581,604	2,732	5.06
6	MAINTENANCE & REPAIRS		170,612	5,656	176,268	142	6
7	OPERATION OF PLANT		562,953	30,627	593,580	190	7
8	LAUNDRY & LINEN SERVICE		79,595		79,595		8
9	HOUSEKEEPING		40,980	331	41,311	339	9
10	DIETARY		197,016	2,761	199,777	167	10
11	CAFETERIA					174	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		79,910	1,517	81,427	418	13
14	CENTRAL SERVICES & SUPPLY		117,826	4,048	121,874	121	14
15	PHARMACY		65,154	963	66,117	382	15
16	MEDICAL RECORDS & LIBRARY		83,244	1,339	84,583	157	16
17	SOCIAL SERVICE		22,484		22,484	214	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					632	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		949,480	7,801	957,281	2,317	30
31	INTENSIVE CARE UNIT		129,181	5,964	135,145	794	31
40	SUBPROVIDER - IPF		284,022	531	284,553	813	40
43	NURSERY		28,567	497	29,064	496	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		130,623	35,136	165,759	593	50
51	RECOVERY ROOM					125	51
52	DELIVERY ROOM & LABOR ROOM		87,480	5,986	93,466	1,399	52
53	ANESTHESIOLOGY		16,852	16	16,868		53
54	RADIOLOGY-DIAGNOSTIC		242,164	162,037	404,201	875	54
57	COMPUTED TOMOGRAPHY (CT) SCAN					131	57
58	MAGNETIC RESONANCE IMAGING (MRI)					51	58
60	LABORATORY		160,609	20,767	181,376	622	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.					13	63
65	RESPIRATORY THERAPY		29,581	5,570	35,151	252	65
66	PHYSICAL THERAPY		38,930	96	39,026	333	66
69	ELECTROCARDIOLOGY		22,574	2,087	24,661	168	69
70	ELECTROENCEPHALOGRAPHY		14,261	972	15,233	21	70
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
75	ASC (NON-DISTINCT PART)					118	75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		136,120	19	136,139	652	90
91	EMERGENCY		83,695	6,758	90,453	1,008	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		4,355,093	320,051	4,675,144	16,449	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,379	54	3,433	19	190
192	PHYSICIANS' PRIVATE OFFICES		207,154	19,116	226,270	1,680	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		4,565,626	339,221	4,904,847	18,148	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	A+G	MAINTEN-ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.06	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	584,336					5.06
6	MAINTENANCE & REPAIRS	15,631	192,041				6
7	OPERATION OF PLANT	19,976	28,347	642,093			7
8	LAUNDRY & LINEN SERVICE	5,038	4,008	15,721	104,362		8
9	HOUSEKEEPING	17,971	2,064	8,094		69,779	9
10	DIETARY	10,370	9,920	38,913			10
11	CAFETERIA	4,505					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	12,167	4,024	15,783			13
14	CENTRAL SERVICES & SUPPLY	5,164	5,933	23,272			14
15	PHARMACY	12,577	3,281	12,869			15
16	MEDICAL RECORDS & LIBRARY	6,339	4,192	16,442		419	16
17	SOCIAL SERVICE	6,302	1,132	4,441			17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	12,722				5,878	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	67,486	47,810	187,536	54,268	15,512	30
31	INTENSIVE CARE UNIT	24,197	6,505	25,515	10,436	3,087	31
40	SUBPROVIDER - IPF	25,460	14,302	56,098	28,178	6,025	40
43	NURSERY	9,940	1,438	5,642	11,480		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	34,935	6,577	25,800		6,740	50
51	RECOVERY ROOM	3,482					51
52	DELIVERY ROOM & LABOR ROOM	34,213	4,405	17,278		14,035	52
53	ANESTHESIOLOGY	8,947	849	3,328			53
54	RADIOLOGY-DIAGNOSTIC	33,584	12,194	47,831		6,192	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	4,563					57
58	MAGNETIC RESONANCE IMAGING (MRI)	1,559					58
60	LABORATORY	29,229	8,087	31,722		1,027	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,242					63
65	RESPIRATORY THERAPY	9,334	1,489	5,843		315	65
66	PHYSICAL THERAPY	9,946	1,960	7,689		472	66
69	ELECTROCARDIOLOGY	5,720	1,137	4,459		419	69
70	ELECTROENCEPHALOGRAPHY	750	718	2,817			70
72	IMPL. DEV. CHARGED TO PATIENT	649					72
73	DRUGS CHARGED TO PATIENTS	31,911				293	73
75	ASC (NON-DISTINCT PART)	3,344					75
76	HEMODIALYSIS	2,952					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	19,724	6,854	26,886		945	90
91	EMERGENCY	31,580	4,214	16,531		4,996	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	527,509	181,440	600,510	104,362	66,355	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,081	170	667		1,471	190
192	PHYSICIANS' PRIVATE OFFICES	55,746	10,431	40,916		1,953	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	584,336	192,041	642,093	104,362	69,779	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	259,147					10
11	CAFETERIA		4,679				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		248	114,067			13
14	CENTRAL SERVICES & SUPPLY		70		156,434		14
15	PHARMACY		112			95,338	15
16	MEDICAL RECORDS & LIBRARY		45				16
17	SOCIAL SERVICE		62				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		59	129			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	151,134	929	45,857			30
31	INTENSIVE CARE UNIT	29,796	251	12,692			31
40	SUBPROVIDER - IPF	78,217	373	9,090			40
43	NURSERY		114	5,048			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		159	5,044	156,434		50
51	RECOVERY ROOM		32	1,926			51
52	DELIVERY ROOM & LABOR ROOM		402	15,887			52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		296	371			54
57	COMPUTED TOMOGRAPHY (CT) SCAN		63				57
58	MAGNETIC RESONANCE IMAGING (MRI)		24				58
60	LABORATORY		275				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY		115				65
66	PHYSICAL THERAPY		61				66
69	ELECTROCARDIOLOGY		72				69
70	ELECTROENCEPHALOGRAPHY		7				70
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS					95,338	73
75	ASC (NON-DISTINCT PART)		23	1,006			75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		231	2,251			90
91	EMERGENCY		469	13,923			91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	259,147	4,492	113,224	156,434	95,338	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		11				190
192	PHYSICIANS' PRIVATE OFFICES		176	843			192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	259,147	4,679	114,067	156,434	95,338	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	112,177					16
17	SOCIAL SERVICE		34,635				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD			19,420			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	11,979	18,849		1,560,958		30
31	INTENSIVE CARE UNIT	4,333	2,347		255,098		31
40	SUBPROVIDER - IPF	5,762	8,971		517,842		40
43	NURSERY	2,018	4,468		69,708		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,131			411,172		50
51	RECOVERY ROOM	564			6,129		51
52	DELIVERY ROOM & LABOR ROOM	4,662			185,747		52
53	ANESTHESIOLOGY	3,913			33,905		53
54	RADIOLOGY-DIAGNOSTIC	8,991			514,535		54
57	COMPUTED TOMOGRAPHY (CT) SCAN	6,632			11,389		57
58	MAGNETIC RESONANCE IMAGING (MRI)	1,341			2,975		58
60	LABORATORY	9,502			261,840		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,339			6,594		63
65	RESPIRATORY THERAPY	4,315			56,814		65
66	PHYSICAL THERAPY	2,181			61,668		66
69	ELECTROCARDIOLOGY	2,418			39,054		69
70	ELECTROENCEPHALOGRAPHY	373			19,919		70
72	IMPL. DEV. CHARGED TO PATIENT	501			1,150		72
73	DRUGS CHARGED TO PATIENTS	14,265			141,807		73
75	ASC (NON-DISTINCT PART)	662			5,153		75
76	HEMODIALYSIS	427			3,379		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,816			196,498		90
91	EMERGENCY	14,052			177,226		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	112,177	34,635		4,540,560		118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				6,852		190
192	PHYSICIANS' PRIVATE OFFICES				338,015		192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS			19,420	19,420		200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	112,177	34,635	19,420	4,904,847		202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	TOTAL 26	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	1,560,958	30
31	INTENSIVE CARE UNIT	255,098	31
40	SUBPROVIDER - IPF	517,842	40
43	NURSERY	69,708	43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	411,172	50
51	RECOVERY ROOM	6,129	51
52	DELIVERY ROOM & LABOR ROOM	185,747	52
53	ANESTHESIOLOGY	33,905	53
54	RADIOLOGY-DIAGNOSTIC	514,535	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	11,389	57
58	MAGNETIC RESONANCE IMAGING (MRI)	2,975	58
60	LABORATORY	261,840	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	6,594	63
65	RESPIRATORY THERAPY	56,814	65
66	PHYSICAL THERAPY	61,668	66
69	ELECTROCARDIOLOGY	39,054	69
70	ELECTROENCEPHALOGRAPHY	19,919	70
72	IMPL. DEV. CHARGED TO PATIENT	1,150	72
73	DRUGS CHARGED TO PATIENTS	141,807	73
75	ASC (NON-DISTINCT PART)	5,153	75
76	HEMODIALYSIS	3,379	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	196,498	90
91	EMERGENCY	177,226	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	4,540,560	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,852	190
192	PHYSICIANS' PRIVATE OFFICES	338,015	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS	19,420	200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	4,904,847	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET) 1	NEW CAP-REL COSTS MOV EQUIP DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A.06	A+G ACCUM COST 5.06	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	202,656					1
2	CAP REL COSTS-MVBLE EQUIP		1,656,033				2
4	EMPLOYEE BENEFITS	797	935	46,202,626			4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	25,000	89,727	6,972,586	-25,389,444	68,031,334	5.06
6	MAINTENANCE & REPAIRS	7,573	27,614	362,229		1,819,865	6
7	OPERATION OF PLANT	24,988	149,517	484,151		2,325,709	7
8	LAUNDRY & LINEN SERVICE	3,533				586,596	8
9	HOUSEKEEPING	1,819	1,618	863,586		2,092,356	9
10	DIETARY	8,745	13,477	425,748		1,207,372	10
11	CAFETERIA			443,126		524,511	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,547	7,408	1,064,521		1,416,617	13
14	CENTRAL SERVICES & SUPPLY	5,230	19,763	308,872		601,197	14
15	PHARMACY	2,892	4,702	972,403		1,464,264	15
16	MEDICAL RECORDS & LIBRARY	3,695	6,537	399,044		738,013	16
17	SOCIAL SERVICE	998		544,144		733,711	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD			1,607,534		1,481,242	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	42,145	38,081	5,896,798		7,855,912	30
31	INTENSIVE CARE UNIT	5,734	29,115	2,021,617		2,817,155	31
40	SUBPROVIDER - IPF	12,607	2,592	2,069,386		2,964,293	40
43	NURSERY	1,268	2,426	1,261,887		1,157,291	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,798	171,529	1,507,831		4,067,410	50
51	RECOVERY ROOM			318,846		405,387	51
52	DELIVERY ROOM & LABOR ROOM	3,883	29,224	3,560,477		3,983,293	52
53	ANESTHESIOLOGY	748	77			1,041,696	53
54	RADIOLOGY-DIAGNOSTIC	10,749	791,050	2,225,225		3,910,111	54
57	COMPUTED TOMOGRAPHY (CT) SCAN			332,670		531,240	57
58	MAGNETIC RESONANCE IMAGING (MRI)			129,360		181,543	58
60	LABORATORY	7,129	101,380	1,582,069		3,403,059	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.			32,971		610,317	63
65	RESPIRATORY THERAPY	1,313	27,190	642,080		1,086,719	65
66	PHYSICAL THERAPY	1,728	469	847,364		1,157,975	66
69	ELECTROCARDIOLOGY	1,002	10,188	426,290		665,941	69
70	ELECTROENCEPHALOGRAPHY	633	4,744	54,063		87,288	70
72	IMPL. DEV. CHARGED TO PATIENT					75,557	72
73	DRUGS CHARGED TO PATIENTS					3,715,307	73
75	ASC (NON-DISTINCT PART)			299,215		389,284	75
76	HEMODIALYSIS					343,705	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	6,042	92	1,659,826		2,296,446	90
91	EMERGENCY	3,715	32,994	2,564,724		3,676,743	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	193,311	1,562,449	41,880,643	-25,389,444	61,415,125	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	264	48,440		125,801	190
192	PHYSICIANS' PRIVATE OFFICES	9,195	93,320	4,273,543		6,490,408	192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET) 1	NEW CAP-REL COSTS MOV EQUIP DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A.06	A+G ACCUM COST 5.06	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	4,565,626	339,221	7,377,263		25,389,444	202
203	UNIT COST MULT-WS B PT I	22.528946	0.204840	0.159672		0.373202	203
204	COST TO BE ALLOC PER B PT II			18,148		584,336	204
205	UNIT COST MULT-WS B PT II			0.000393		0.008589	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	MAINTENANCE AND REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6	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
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS	169,286					6
7	OPERATION OF PLANT	24,988	144,298				7
8	LAUNDRY & LINEN SERVICE	3,533	3,533	680,476			8
9	HOUSEKEEPING	1,819	1,819		28,802		9
10	DIETARY	8,745	8,745			92,130	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,547	3,547				13
14	CENTRAL SERVICES & SUPPLY	5,230	5,230				14
15	PHARMACY	2,892	2,892				15
16	MEDICAL RECORDS & LIBRARY	3,695	3,695		173		16
17	SOCIAL SERVICE	998	998				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD				2,426		22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	42,145	42,145	353,848	6,403	53,730	30
31	INTENSIVE CARE UNIT	5,734	5,734	68,048	1,274	10,593	31
40	SUBPROVIDER - IPF	12,607	12,607	183,729	2,487	27,807	40
43	NURSERY	1,268	1,268	74,851			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,798	5,798		2,782		50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM	3,883	3,883		5,793		52
53	ANESTHESIOLOGY	748	748				53
54	RADIOLOGY-DIAGNOSTIC	10,749	10,749		2,556		54
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MRI)						58
60	LABORATORY	7,129	7,129		424		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY	1,313	1,313		130		65
66	PHYSICAL THERAPY	1,728	1,728		195		66
69	ELECTROCARDIOLOGY	1,002	1,002		173		69
70	ELECTROENCEPHALOGRAPHY	633	633				70
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS				121		73
75	ASC (NON-DISTINCT PART)						75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	6,042	6,042		390		90
91	EMERGENCY	3,715	3,715		2,062		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	159,941	134,953	680,476	27,389	92,130	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150		607		190
192	PHYSICIANS' PRIVATE OFFICES	9,195	9,195		806		192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAINTEN-ANCE AND REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE PATIENT DAYS 8	HOUSE-KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,499,042	3,562,547	944,896	2,944,989	2,002,966	202
203	UNIT COST MULT-WS B PT I	14.762249	24.688818	1.388581	102.249462	21.740649	203
204	COST TO BE ALLOC PER B PT II	192,041	642,093	104,362	69,779	259,147	204
205	UNIT COST MULT-WS B PT II	1.134417	4.449771	0.153366	2.422714	2.812841	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA FULL TIME HOURS 11	NURSING ADMINI-STRATION (FULL TIME TIME) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	87,765					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	4,659	745,375				13
14	CENTRAL SERVICES & SUPPLY	1,319		100			14
15	PHARMACY	2,107			100		15
16	MEDICAL RECORDS & LIBRARY	837				295,434,832	16
17	SOCIAL SERVICE	1,168					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	1,105	840				22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	17,429	299,648			31,524,939	30
31	INTENSIVE CARE UNIT	4,700	82,939			11,401,359	31
40	SUBPROVIDER - IPF	7,004	59,397			15,162,578	40
43	NURSERY	2,131	32,989			5,310,011	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,983	32,958	100		24,028,218	50
51	RECOVERY ROOM	605	12,588			1,484,739	51
52	DELIVERY ROOM & LABOR ROOM	7,532	103,814			12,269,335	52
53	ANESTHESIOLOGY					10,298,286	53
54	RADIOLOGY-DIAGNOSTIC	5,545	2,422			23,661,286	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	1,176				17,452,032	57
58	MAGNETIC RESONANCE IMAGING (MRI)	453				3,528,099	58
60	LABORATORY	5,163				25,005,812	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.					3,523,551	63
65	RESPIRATORY THERAPY	2,156				11,354,124	65
66	PHYSICAL THERAPY	1,146				5,740,664	66
69	ELECTROCARDIOLOGY	1,345				6,363,590	69
70	ELECTROENCEPHALOGRAPHY	139				981,084	70
72	IMPL. DEV. CHARGED TO PATIENT					1,317,189	72
73	DRUGS CHARGED TO PATIENTS				100	37,769,694	73
75	ASC (NON-DISTINCT PART)	424	6,576			1,743,308	75
76	HEMODIALYSIS					1,123,462	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	4,332	14,710			7,411,527	90
91	EMERGENCY	8,800	90,983			36,979,945	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	84,258	739,864	100	100	295,434,832	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	212					190
192	PHYSICIANS' PRIVATE OFFICES	3,295	5,511				192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA FULL TIME HOURS 11	NURSING ADMINI-STRATION (FULL TIME TIME) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	720,260	2,123,469	1,042,720	2,142,113	1,183,771	202
203	UNIT COST MULT-WS B PT I	8.206688	2.848860	10,427.200000	21,421.130000	0.004007	203
204	COST TO BE ALLOC PER B PT II	4,679	114,067	156,434	95,338	112,177	204
205	UNIT COST MULT-WS B PT II	0.053313	0.153033	1,564.340000	953.380000	0.000380	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5.01	COMMUNICATIONS			5.01
5.02	PURCHASING, RECEIVING			5.02
5.03	ADMITTING			5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE			5.04
5.05	DATA PROCESSING			5.05
5.06	ADMINISTRATIVE & GENERAL			5.06
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
12	MAINTENANCE OF PERSONNEL			12
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE	36,094		17
19	NONPHYSICIAN ANESTHETISTS			19
20	NURSING SCHOOL			20
21	I&R SRVCES-SALARY & FRINGES APPRVD			21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		250	22
23	PARAMED ED PRGM-(SPECIFY)			23
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	19,643	100	30
31	INTENSIVE CARE UNIT	2,446		31
40	SUBPROVIDER - IPF	9,349		40
43	NURSERY	4,656		43
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM			50
51	RECOVERY ROOM			51
52	DELIVERY ROOM & LABOR ROOM			52
53	ANESTHESIOLOGY			53
54	RADIOLOGY-DIAGNOSTIC			54
57	COMPUTED TOMOGRAPHY (CT) SCAN			57
58	MAGNETIC RESONANCE IMAGING (MRI)			58
60	LABORATORY			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63	BLOOD STORING, PROCESSING & TRANS.			63
65	RESPIRATORY THERAPY			65
66	PHYSICAL THERAPY			66
69	ELECTROCARDIOLOGY			69
70	ELECTROENCEPHALOGRAPHY			70
72	IMPL. DEV. CHARGED TO PATIENT			72
73	DRUGS CHARGED TO PATIENTS			73
75	ASC (NON-DISTINCT PART)			75
76	HEMODIALYSIS			76
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	OUTPATIENT SERVICE COST CENTERS			
90	CLINIC		50	90
91	EMERGENCY		100	91
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
99.10	CORF			99.10
99.20	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	OUTPATIENT SPEECH PATHOLOGY			99.40
	SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	36,094	250	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192	PHYSICIANS' PRIVATE OFFICES			192
192.01	FUND DEVELOPMENT			192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	1,056,490	2,293,562	202
203	UNIT COST MULT-WS B PT I	29.270516	9,174.248000	203
204	COST TO BE ALLOC PER B PT II	34,635	19,420	204
205	UNIT COST MULT-WS B PT II	0.959578	77.680000	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	16,462,574		16,462,574		16,462,574	30
31	INTENSIVE CARE UNIT	4,941,925		4,941,925		4,941,925	31
40	SUBPROVIDER - IPF	6,242,992		6,242,992		6,242,992	40
43	NURSERY	2,012,185		2,012,185		2,012,185	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	7,355,947		7,355,947		7,355,947	50
51	RECOVERY ROOM	603,453		603,453		603,453	51
52	DELIVERY ROOM & LABOR ROOM	6,622,114		6,622,114		6,622,114	52
53	ANESTHESIOLOGY	1,501,233		1,501,233		1,501,233	53
54	RADIOLOGY-DIAGNOSTIC	6,201,998		6,201,998		6,201,998	54
57	COMPUTED TOMOGRAPHY (CT) SC	809,081		809,081		809,081	57
58	MAGNETIC RESONANCE IMAGING	267,150		267,150		267,150	58
60	LABORATORY	5,140,257		5,140,257		5,140,257	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
63	BLOOD STORING, PROCESSING &	852,208		852,208		852,208	63
65	RESPIRATORY THERAPY	1,620,566		1,620,566		1,620,566	65
66	PHYSICAL THERAPY	1,710,652		1,710,652		1,710,652	66
69	ELECTROCARDIOLOGY	1,008,228		1,008,228		1,008,228	69
70	ELECTROENCEPHALOGRAPHY	149,909		149,909		149,909	70
72	IMPL. DEV. CHARGED TO PATIE	109,033		109,033		109,033	72
73	DRUGS CHARGED TO PATIENTS	7,407,661		7,407,661		7,407,661	73
75	ASC (NON-DISTINCT PART)	563,765		563,765		563,765	75
76	HEMODIALYSIS	476,478		476,478		476,478	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,538,881		3,538,881		3,538,881	90
91	EMERGENCY	5,885,906		5,885,906		5,885,906	91
92	OBSERVATION BEDS	58,000		58,000		58,000	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	81,542,196		81,542,196		81,542,196	200
201	LESS OBSERVATION BEDS	58,000		58,000		58,000	201
202	TOTAL (SEE INSTRUCTIONS)	81,484,196		81,484,196		81,484,196	202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	28,903,621		28,903,621				30
31	INTENSIVE CARE UNIT	11,401,359		11,401,359				31
40	SUBPROVIDER - IPF	15,162,578		15,162,578				40
43	NURSERY	5,310,011		5,310,011				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,370,750	14,657,468	24,028,218	0.306138	0.306138	0.306138	50
51	RECOVERY ROOM	406,455	1,078,284	1,484,739	0.406437	0.406437	0.406437	51
52	DELIVERY ROOM & LABOR ROOM	10,092,797	2,176,538	12,269,335	0.539729	0.539729	0.539729	52
53	ANESTHESIOLOGY	3,854,301	6,443,985	10,298,286	0.145775	0.145775	0.145775	53
54	RADIOLOGY-DIAGNOSTIC	4,912,003	18,749,283	23,661,286	0.262116	0.262116	0.262116	54
57	COMPUTED TOMOGRAPHY (CT) SC	5,326,541	12,125,491	17,452,032	0.046360	0.046360	0.046360	57
58	MAGNETIC RESONANCE IMAGING	370,079	3,158,020	3,528,099	0.075721	0.075721	0.075721	58
60	LABORATORY	12,767,202	12,238,610	25,005,812	0.205562	0.205562	0.205562	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
63	BLOOD STORING, PROCESSING &	2,990,446	533,105	3,523,551	0.241861	0.241861	0.241861	63
65	RESPIRATORY THERAPY	10,930,591	423,533	11,354,124	0.142729	0.142729	0.142729	65
66	PHYSICAL THERAPY	545,312	5,195,352	5,740,664	0.297989	0.297989	0.297989	66
69	ELECTROCARDIOLOGY	2,631,302	3,732,288	6,363,590	0.158437	0.158437	0.158437	69
70	ELECTROENCEPHALOGRAPHY	223,154	757,930	981,084	0.152799	0.152799	0.152799	70
72	IMPL. DEV. CHARGED TO PATIE	746,119	571,070	1,317,189	0.082777	0.082777	0.082777	72
73	DRUGS CHARGED TO PATIENTS	20,772,346	16,997,348	37,769,694	0.196127	0.196127	0.196127	73
75	ASC (NON-DISTINCT PART)	89,688	1,653,620	1,743,308	0.323388	0.323388	0.323388	75
76	HEMODIALYSIS	1,065,645	57,817	1,123,462	0.424116	0.424116	0.424116	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	18,102	7,393,425	7,411,527	0.477483	0.477483	0.477483	90
91	EMERGENCY	6,731,121	30,248,824	36,979,945	0.159165	0.159165	0.159165	91
92	OBSERVATION BEDS		2,621,318	2,621,318	0.022126	0.022126	0.022126	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	154,621,523	140,813,309	295,434,832				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	154,621,523	140,813,309	295,434,832				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	1,560,958		1,560,958	15,611	99.99	5,845	584,442	30
31	INTENSIVE CARE UNIT	255,098		255,098	3,513	72.62	1,236	89,758	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	517,842		517,842	9,927	52.17	3,186	166,214	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	69,708		69,708	3,781	18.44			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	2,403,606		2,403,606	32,832		10,267	840,414	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	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						
50	OPERATING ROOM	411,172	24,028,218	0.017112	2,332,500	39,914	50
51	RECOVERY ROOM	6,129	1,484,739	0.004128	116,112	479	51
52	DELIVERY ROOM & LABOR ROOM	185,747	12,269,335	0.015139	33,218	503	52
53	ANESTHESIOLOGY	33,905	10,298,286	0.003292	745,744	2,455	53
54	RADIOLOGY-DIAGNOSTIC	514,535	23,661,286	0.021746	2,085,647	45,354	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	11,389	17,452,032	0.000653	1,504,176	982	57
58	MAGNETIC RESONANCE IMAGING (M	2,975	3,528,099	0.000843	130,324	110	58
60	LABORATORY	261,840	25,005,812	0.010471	3,781,458	39,596	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,594	3,523,551	0.001871	879,626	1,646	63
65	RESPIRATORY THERAPY	56,814	11,354,124	0.005004	4,968,307	24,861	65
66	PHYSICAL THERAPY	61,668	5,740,664	0.010742	319,737	3,435	66
69	ELECTROCARDIOLOGY	39,054	6,363,590	0.006137	1,137,082	6,978	69
70	ELECTROENCEPHALOGRAPHY	19,919	981,084	0.020303	104,228	2,116	70
72	IMPL. DEV. CHARGED TO PATIENT	1,150	1,317,189	0.000873	336,577	294	72
73	DRUGS CHARGED TO PATIENTS	141,807	37,769,694	0.003755	6,616,925	24,847	73
75	ASC (NON-DISTINCT PART)	5,153	1,743,308	0.002956	19,980	59	75
76	HEMODIALYSIS	3,379	1,123,462	0.003008	557,036	1,676	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	196,498	7,411,527	0.026512	4,163	110	90
91	EMERGENCY	177,226	36,979,945	0.004792	1,858,012	8,904	91
92	OBSERVATION BEDS	5,500	2,621,318	0.002098			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	2,142,454	234,657,263		27,530,852	204,319	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	15,611		5,845		30
31	INTENSIVE CARE UNIT	3,513		1,236		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	9,927		3,186		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	3,781				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	32,832		10,267		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	COMPUTED TOMOGRAPHY (CT) SCAN							57
58	MAGNETIC RESONANCE IMAGING (M							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES
[ ] TITLE V [XX] HOSPITAL (14-0095) [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS
[XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA
[ ] TITLE XIX [ ] IRF [ ] NF

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,028,218			2,332,500		2,128,578		50
51	RECOVERY ROOM	1,484,739			116,112		275,847		51
52	DELIVERY ROOM & LABOR ROOM	12,269,335			33,218		4,667		52
53	ANESTHESIOLOGY	10,298,286			745,744		1,114,615		53
54	RADIOLOGY-DIAGNOSTIC	23,661,286			2,085,647		2,098,739		54
57	COMPUTED TOMOGRAPHY (CT) SCA	17,452,032			1,504,176		2,002,311		57
58	MAGNETIC RESONANCE IMAGING (	3,528,099			130,324		508,067		58
60	LABORATORY	25,005,812			3,781,458		248,418		60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,523,551			879,626		46,159		63
65	RESPIRATORY THERAPY	11,354,124			4,968,307		316,274		65
66	PHYSICAL THERAPY	5,740,664			319,737		35,245		66
69	ELECTROCARDIOLOGY	6,363,590			1,137,082		947,761		69
70	ELECTROENCEPHALOGRAPHY	981,084			104,228		187,931		70
72	IMPL. DEV. CHARGED TO PATIEN	1,317,189			336,577		150,461		72
73	DRUGS CHARGED TO PATIENTS	37,769,694			6,616,925		6,752,032		73
75	ASC (NON-DISTINCT PART)	1,743,308			19,980		258,714		75
76	HEMODIALYSIS	1,123,462			557,036		13,930		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	7,411,527			4,163		3,098,736		90
91	EMERGENCY	36,979,945			1,858,012		1,789,079		91
92	OBSERVATION BEDS	2,621,318					528,413		92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	234,657,263			27,530,852		22,505,977		200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	S/B-SNF	
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF	
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.306138	2,128,578			651,639			50
51	RECOVERY ROOM	0.406437	275,847			112,114			51
52	DELIVERY ROOM & LABOR ROOM	0.539729	4,667			2,519			52
53	ANESTHESIOLOGY	0.145775	1,114,615			162,483			53
54	RADIOLOGY-DIAGNOSTIC	0.262116	2,098,739			550,113			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360	2,002,311			92,827			57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721	508,067			38,471			58
60	LABORATORY	0.205562	248,418			51,065			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861	46,159			11,164			63
65	RESPIRATORY THERAPY	0.142729	316,274			45,141			65
66	PHYSICAL THERAPY	0.297989	35,245			10,503			66
69	ELECTROCARDIOLOGY	0.158437	947,761			150,160			69
70	ELECTROENCEPHALOGRAPHY	0.152799	187,931			28,716			70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777	150,461			12,455			72
73	DRUGS CHARGED TO PATIENTS	0.196127	6,752,032		14,504	1,324,256		2,845	73
75	ASC (NON-DISTINCT PART)	0.323388	258,714			83,665			75
76	HEMODIALYSIS	0.424116	13,930			5,908			76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.477483	3,098,736			1,479,594			90
91	EMERGENCY	0.159165	1,789,079			284,759			91
92	OBSERVATION BEDS	0.022126	528,413			11,692			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)		22,505,977		14,504	5,109,244		2,845	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		22,505,977		14,504	5,109,244		2,845	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES [ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX [ ] HOSPITAL [XX] IPF (14-S095) [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	411,172	24,028,218	0.017112	10,109	173	50
51	RECOVERY ROOM	6,129	1,484,739	0.004128	1,165	5	51
52	DELIVERY ROOM & LABOR ROOM	185,747	12,269,335	0.015139			52
53	ANESTHESIOLOGY	33,905	10,298,286	0.003292	5,007	16	53
54	RADIOLOGY-DIAGNOSTIC	514,535	23,661,286	0.021746	56,543	1,230	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	11,389	17,452,032	0.000653	37,026	24	57
58	MAGNETIC RESONANCE IMAGING (M	2,975	3,528,099	0.000843	8,524	7	58
60	LABORATORY	261,840	25,005,812	0.010471	374,831	3,925	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,594	3,523,551	0.001871	19,905	37	63
65	RESPIRATORY THERAPY	56,814	11,354,124	0.005004	139,179	696	65
66	PHYSICAL THERAPY	61,668	5,740,664	0.010742	11,464	123	66
69	ELECTROCARDIOLOGY	39,054	6,363,590	0.006137	81,243	499	69
70	ELECTROENCEPHALOGRAPHY	19,919	981,084	0.020303	22,510	457	70
72	IMPL. DEV. CHARGED TO PATIENT	1,150	1,317,189	0.000873			72
73	DRUGS CHARGED TO PATIENTS	141,807	37,769,694	0.003755	1,053,543	3,956	73
75	ASC (NON-DISTINCT PART)	5,153	1,743,308	0.002956	284	1	75
76	HEMODIALYSIS	3,379	1,123,462	0.003008	17,904	54	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	196,498	7,411,527	0.026512			90
91	EMERGENCY	177,226	36,979,945	0.004792	173,123	830	91
92	OBSERVATION BEDS	5,500	2,621,318	0.002098			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	2,142,454	234,657,263		2,012,360	12,033	200

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	COMPUTED TOMOGRAPHY (CT) SCAN							57
58	MAGNETIC RESONANCE IMAGING (M							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,028,218			10,109				50
51	RECOVERY ROOM	1,484,739			1,165				51
52	DELIVERY ROOM & LABOR ROOM	12,269,335							52
53	ANESTHESIOLOGY	10,298,286			5,007				53
54	RADIOLOGY-DIAGNOSTIC	23,661,286			56,543				54
57	COMPUTED TOMOGRAPHY (CT) SCA	17,452,032			37,026				57
58	MAGNETIC RESONANCE IMAGING (	3,528,099			8,524				58
60	LABORATORY	25,005,812			374,831				60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,523,551			19,905				63
65	RESPIRATORY THERAPY	11,354,124			139,179				65
66	PHYSICAL THERAPY	5,740,664			11,464				66
69	ELECTROCARDIOLOGY	6,363,590			81,243				69
70	ELECTROENCEPHALOGRAPHY	981,084			22,510				70
72	IMPL. DEV. CHARGED TO PATIEN	1,317,189							72
73	DRUGS CHARGED TO PATIENTS	37,769,694			1,053,543				73
75	ASC (NON-DISTINCT PART)	1,743,308			284				75
76	HEMODIALYSIS	1,123,462			17,904				76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	7,411,527							90
91	EMERGENCY	36,979,945			173,123				91
92	OBSERVATION BEDS	2,621,318							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	234,657,263			2,012,360				200

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[XX]	IPF (14-S095)	[ ]	SNF	[ ]	S/B-NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.306138							50
51	RECOVERY ROOM	0.406437							51
52	DELIVERY ROOM & LABOR ROOM	0.539729							52
53	ANESTHESIOLOGY	0.145775							53
54	RADIOLOGY-DIAGNOSTIC	0.262116							54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721							58
60	LABORATORY	0.205562							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861							63
65	RESPIRATORY THERAPY	0.142729							65
66	PHYSICAL THERAPY	0.297989							66
69	ELECTROCARDIOLOGY	0.158437							69
70	ELECTROENCEPHALOGRAPHY	0.152799							70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777							72
73	DRUGS CHARGED TO PATIENTS	0.196127							73
75	ASC (NON-DISTINCT PART)	0.323388							75
76	HEMODIALYSIS	0.424116							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.477483							90
91	EMERGENCY	0.159165							91
92	OBSERVATION BEDS	0.022126							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	1,560,958		1,560,958	15,611	99.99	7,858	785,721	30
31	INTENSIVE CARE UNIT	255,098		255,098	3,513	72.62	1,758	127,666	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	517,842		517,842	9,927	52.17	4,863	253,703	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	69,708		69,708	3,781	18.44	3,248	59,893	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	2,403,606		2,403,606	32,832		17,727	1,226,983	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	411,172	24,028,218	0.017112			50
51	RECOVERY ROOM	6,129	1,484,739	0.004128			51
52	DELIVERY ROOM & LABOR ROOM	185,747	12,269,335	0.015139			52
53	ANESTHESIOLOGY	33,905	10,298,286	0.003292			53
54	RADIOLOGY-DIAGNOSTIC	514,535	23,661,286	0.021746			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	11,389	17,452,032	0.000653			57
58	MAGNETIC RESONANCE IMAGING (M	2,975	3,528,099	0.000843			58
60	LABORATORY	261,840	25,005,812	0.010471			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,594	3,523,551	0.001871			63
65	RESPIRATORY THERAPY	56,814	11,354,124	0.005004			65
66	PHYSICAL THERAPY	61,668	5,740,664	0.010742			66
69	ELECTROCARDIOLOGY	39,054	6,363,590	0.006137			69
70	ELECTROENCEPHALOGRAPHY	19,919	981,084	0.020303			70
72	IMPL. DEV. CHARGED TO PATIENT	1,150	1,317,189	0.000873			72
73	DRUGS CHARGED TO PATIENTS	141,807	37,769,694	0.003755			73
75	ASC (NON-DISTINCT PART)	5,153	1,743,308	0.002956			75
76	HEMODIALYSIS	3,379	1,123,462	0.003008			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	196,498	7,411,527	0.026512			90
91	EMERGENCY	177,226	36,979,945	0.004792			91
92	OBSERVATION BEDS	5,500	2,621,318	0.002098			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	2,142,454	234,657,263				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	15,611		7,858		30
31	INTENSIVE CARE UNIT	3,513		1,758		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	9,927		4,863		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	3,781		3,248		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	32,832		17,727		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	COMPUTED TOMOGRAPHY (CT) SCAN							57
58	MAGNETIC RESONANCE IMAGING (M							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX] TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,028,218							50
51	RECOVERY ROOM	1,484,739							51
52	DELIVERY ROOM & LABOR ROOM	12,269,335							52
53	ANESTHESIOLOGY	10,298,286							53
54	RADIOLOGY-DIAGNOSTIC	23,661,286							54
57	COMPUTED TOMOGRAPHY (CT) SCA	17,452,032							57
58	MAGNETIC RESONANCE IMAGING (	3,528,099							58
60	LABORATORY	25,005,812							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,523,551							63
65	RESPIRATORY THERAPY	11,354,124							65
66	PHYSICAL THERAPY	5,740,664							66
69	ELECTROCARDIOLOGY	6,363,590							69
70	ELECTROENCEPHALOGRAPHY	981,084							70
72	IMPL. DEV. CHARGED TO PATIEN	1,317,189							72
73	DRUGS CHARGED TO PATIENTS	37,769,694							73
75	ASC (NON-DISTINCT PART)	1,743,308							75
76	HEMODIALYSIS	1,123,462							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	7,411,527							90
91	EMERGENCY	36,979,945							91
92	OBSERVATION BEDS	2,621,318							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	234,657,263							200

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

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.306138							50
51	RECOVERY ROOM	0.406437							51
52	DELIVERY ROOM & LABOR ROOM	0.539729							52
53	ANESTHESIOLOGY	0.145775							53
54	RADIOLOGY-DIAGNOSTIC	0.262116							54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721							58
60	LABORATORY	0.205562							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861							63
65	RESPIRATORY THERAPY	0.142729							65
66	PHYSICAL THERAPY	0.297989							66
69	ELECTROCARDIOLOGY	0.158437							69
70	ELECTROENCEPHALOGRAPHY	0.152799							70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777							72
73	DRUGS CHARGED TO PATIENTS	0.196127							73
75	ASC (NON-DISTINCT PART)	0.323388							75
76	HEMODIALYSIS	0.424116							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.477483							90
91	EMERGENCY	0.159165							91
92	OBSERVATION BEDS	0.022126							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	411,172	24,028,218	0.017112			50
51	RECOVERY ROOM	6,129	1,484,739	0.004128			51
52	DELIVERY ROOM & LABOR ROOM	185,747	12,269,335	0.015139			52
53	ANESTHESIOLOGY	33,905	10,298,286	0.003292			53
54	RADIOLOGY-DIAGNOSTIC	514,535	23,661,286	0.021746			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	11,389	17,452,032	0.000653			57
58	MAGNETIC RESONANCE IMAGING (M	2,975	3,528,099	0.000843			58
60	LABORATORY	261,840	25,005,812	0.010471			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	6,594	3,523,551	0.001871			63
65	RESPIRATORY THERAPY	56,814	11,354,124	0.005004			65
66	PHYSICAL THERAPY	61,668	5,740,664	0.010742			66
69	ELECTROCARDIOLOGY	39,054	6,363,590	0.006137			69
70	ELECTROENCEPHALOGRAPHY	19,919	981,084	0.020303			70
72	IMPL. DEV. CHARGED TO PATIENT	1,150	1,317,189	0.000873			72
73	DRUGS CHARGED TO PATIENTS	141,807	37,769,694	0.003755			73
75	ASC (NON-DISTINCT PART)	5,153	1,743,308	0.002956			75
76	HEMODIALYSIS	3,379	1,123,462	0.003008			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	196,498	7,411,527	0.026512			90
91	EMERGENCY	177,226	36,979,945	0.004792			91
92	OBSERVATION BEDS	5,500	2,621,318	0.002098			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	2,142,454	234,657,263				200

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	COMPUTED TOMOGRAPHY (CT) SCAN							57
58	MAGNETIC RESONANCE IMAGING (M							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS
	[ ] TITLE XVIII-PT A	[XX] IPF (14-S095)	[ ] SNF		[ ] TEFRA
	[XX] TITLE XIX	[ ] IRF	[ ] NF		[ ] OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	24,028,218							50
51	RECOVERY ROOM	1,484,739							51
52	DELIVERY ROOM & LABOR ROOM	12,269,335							52
53	ANESTHESIOLOGY	10,298,286							53
54	RADIOLOGY-DIAGNOSTIC	23,661,286							54
57	COMPUTED TOMOGRAPHY (CT) SCA	17,452,032							57
58	MAGNETIC RESONANCE IMAGING (	3,528,099							58
60	LABORATORY	25,005,812							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,523,551							63
65	RESPIRATORY THERAPY	11,354,124							65
66	PHYSICAL THERAPY	5,740,664							66
69	ELECTROCARDIOLOGY	6,363,590							69
70	ELECTROENCEPHALOGRAPHY	981,084							70
72	IMPL. DEV. CHARGED TO PATIEN	1,317,189							72
73	DRUGS CHARGED TO PATIENTS	37,769,694							73
75	ASC (NON-DISTINCT PART)	1,743,308							75
76	HEMODIALYSIS	1,123,462							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	7,411,527							90
91	EMERGENCY	36,979,945							91
92	OBSERVATION BEDS	2,621,318							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	234,657,263							200

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[XX]	IPF (14-S095)	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES - PPS REIMBURSED SERVICES	PROGRAM CHARGES - COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES - COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS - PPS SERVICES	PROGRAM COSTS - COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS - COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.306138							50
51	RECOVERY ROOM	0.406437							51
52	DELIVERY ROOM & LABOR ROOM	0.539729							52
53	ANESTHESIOLOGY	0.145775							53
54	RADIOLOGY-DIAGNOSTIC	0.262116							54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721							58
60	LABORATORY	0.205562							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861							63
65	RESPIRATORY THERAPY	0.142729							65
66	PHYSICAL THERAPY	0.297989							66
69	ELECTROCARDIOLOGY	0.158437							69
70	ELECTROENCEPHALOGRAPHY	0.152799							70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777							72
73	DRUGS CHARGED TO PATIENTS	0.196127							73
75	ASC (NON-DISTINCT PART)	0.323388							75
76	HEMODIALYSIS	0.424116							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.477483							90
91	EMERGENCY	0.159165							91
92	OBSERVATION BEDS	0.022126							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST — PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0095)	[ ]	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)	15,611	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,611	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,556	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)	5,845	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)	16,462,574	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	16,462,574	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	28,903,621	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	28,903,621	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.569568	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,858.04	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	16,462,574	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,054.55	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	6,163,845	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)	6,163,845	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	4,941,925	3,513	1,406.75	1,236	1,738,743	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)					5,370,780	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					13,273,368	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					674,200	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					204,319	51
52	TOTAL PROGRAM EXCLUDABLE COST					878,519	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					12,394,849	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						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 INSTRUCTIONS) (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (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)	55	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,054.55	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	58,000	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	1,560,958	16,462,574	0.094819	58,000	5,500	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	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)	9,927	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,927	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,927	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)	3,186	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,242,992	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,242,992	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.456248	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,378.40	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,242,992	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	628.89	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,003,644	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	2,003,644	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	384,807	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,388,451	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	166,214	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	12,033	51
52	TOTAL PROGRAM EXCLUDABLE COST	178,247	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,210,204	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		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 INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	15,611	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	15,611	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,556	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)	7,858	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)	3,781	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	3,248	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)	16,462,574	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	16,462,574	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	28,903,621	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	28,903,621	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.569568	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,858.04	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	16,462,574	37

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

CHECK	[ ] TITLE V-INPT	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[XX] TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,054.55	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	8,286,654	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)	8,286,654	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)	2,012,185	3,781	532.18	3,248	1,728,521	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,941,925	3,513	1,406.75	1,758	2,473,067	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					12,488,242	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	973,280	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST	973,280	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	11,514,962	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		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 INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (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)	55	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST — PART I

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	9,927	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,927	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,927	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)	4,863	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,242,992	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,242,992	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	13,683,345	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.456248	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,378.40	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,242,992	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	628.89	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,058,292	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)	3,058,292	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	3,058,292	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	253,703	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST	253,703	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,804,589	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 THE MARKET 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 OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		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 INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	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		10,350,098		30
31	INTENSIVE CARE UNIT		5,436,920		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306138	2,332,500	714,067	50
51	RECOVERY ROOM	0.406437	116,112	47,192	51
52	DELIVERY ROOM & LABOR ROOM	0.539729	33,218	17,929	52
53	ANESTHESIOLOGY	0.145775	745,744	108,711	53
54	RADIOLOGY-DIAGNOSTIC	0.262116	2,085,647	546,681	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360	1,504,176	69,734	57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721	130,324	9,868	58
60	LABORATORY	0.205562	3,781,458	777,324	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861	879,626	212,747	63
65	RESPIRATORY THERAPY	0.142729	4,968,307	709,121	65
66	PHYSICAL THERAPY	0.297989	319,737	95,278	66
69	ELECTROCARDIOLOGY	0.158437	1,137,082	180,156	69
70	ELECTROENCEPHALOGRAPHY	0.152799	104,228	15,926	70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777	336,577	27,861	72
73	DRUGS CHARGED TO PATIENTS	0.196127	6,616,925	1,297,758	73
75	ASC (NON-DISTINCT PART)	0.323388	19,980	6,461	75
76	HEMODIALYSIS	0.424116	557,036	236,248	76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.477483	4,163	1,988	90
91	EMERGENCY	0.159165	1,858,012	295,730	91
92	OBSERVATION BEDS	0.022126			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		27,530,852	5,370,780	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		27,530,852		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		4,794,308		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306138	10,109	3,095	50
51	RECOVERY ROOM	0.406437	1,165	473	51
52	DELIVERY ROOM & LABOR ROOM	0.539729			52
53	ANESTHESIOLOGY	0.145775	5,007	730	53
54	RADIOLOGY-DIAGNOSTIC	0.262116	56,543	14,821	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360	37,026	1,717	57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721	8,524	645	58
60	LABORATORY	0.205562	374,831	77,051	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861	19,905	4,814	63
65	RESPIRATORY THERAPY	0.142729	139,179	19,865	65
66	PHYSICAL THERAPY	0.297989	11,464	3,416	66
69	ELECTROCARDIOLOGY	0.158437	81,243	12,872	69
70	ELECTROENCEPHALOGRAPHY	0.152799	22,510	3,440	70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777			72
73	DRUGS CHARGED TO PATIENTS	0.196127	1,053,543	206,628	73
75	ASC (NON-DISTINCT PART)	0.323388	284	92	75
76	HEMODIALYSIS	0.424116	17,904	7,593	76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.477483			90
91	EMERGENCY	0.159165	173,123	27,555	91
92	OBSERVATION BEDS	0.022126			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		2,012,360	384,807	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		2,012,360		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306138			50
51	RECOVERY ROOM	0.406437			51
52	DELIVERY ROOM & LABOR ROOM	0.539729			52
53	ANESTHESIOLOGY	0.145775			53
54	RADIOLOGY-DIAGNOSTIC	0.262116			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360			57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721			58
60	LABORATORY	0.205562			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861			63
65	RESPIRATORY THERAPY	0.142729			65
66	PHYSICAL THERAPY	0.297989			66
69	ELECTROCARDIOLOGY	0.158437			69
70	ELECTROENCEPHALOGRAPHY	0.152799			70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777			72
73	DRUGS CHARGED TO PATIENTS	0.196127			73
75	ASC (NON-DISTINCT PART)	0.323388			75
76	HEMODIALYSIS	0.424116			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.477483			90
91	EMERGENCY	0.159165			91
92	OBSERVATION BEDS	0.022126			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306138			50
51	RECOVERY ROOM	0.406437			51
52	DELIVERY ROOM & LABOR ROOM	0.539729			52
53	ANESTHESIOLOGY	0.145775			53
54	RADIOLOGY-DIAGNOSTIC	0.262116			54
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.046360			57
58	MAGNETIC RESONANCE IMAGING (MRI	0.075721			58
60	LABORATORY	0.205562			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.241861			63
65	RESPIRATORY THERAPY	0.142729			65
66	PHYSICAL THERAPY	0.297989			66
69	ELECTROCARDIOLOGY	0.158437			69
70	ELECTROENCEPHALOGRAPHY	0.152799			70
72	IMPL. DEV. CHARGED TO PATIENT	0.082777			72
73	DRUGS CHARGED TO PATIENTS	0.196127			73
75	ASC (NON-DISTINCT PART)	0.323388			75
76	HEMODIALYSIS	0.424116			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.477483			90
91	EMERGENCY	0.159165			91
92	OBSERVATION BEDS	0.022126			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART A

CHECK [XX] HOSPITAL (14-0095)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	8,684,223	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	457,166	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	201,458	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	108.85	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)	5.59	5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	5.59	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	1.78	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	1.78	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.78	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	2.13	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.90	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	1.90	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.017455	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.016348	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.016348	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	79,038	22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	-3.81	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	79,038	29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.1481	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.5570	31
32	SUM OF LINES 30 AND 31	0.7051	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.4739	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	4,115,453	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	13,335,880	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	13,335,880	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	838,443	50

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0095)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	55,229	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	14,229,552	59
60	PRIMARY PAYER PAYMENTS	5,424	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	14,224,128	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	873,944	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	167,652	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	962,381	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	673,667	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	919,564	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	13,856,199	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	13,856,199	71
72	INTERIM PAYMENTS	13,441,907	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	414,292	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	827,628	75

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0095) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,845	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	5,109,244	2
3	PPS PAYMENTS	4,898,341	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	10,165	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)	2,845	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	14,504	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)	14,504	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)	14,504	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	11,659	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)	2,845	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)	4,908,506	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,103,853	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,807,498	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)	18,033	28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	3,825,531	30
31	PRIMARY PAYER PAYMENTS	127	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,825,404	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)	587,761	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	411,433	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	564,974	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	4,236,837	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)	4,236,837	40
41	INTERIM PAYMENTS	3,997,924	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	238,913	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF (14-S095) [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

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

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0095) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				13,416,581		3,992,629	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01	06/22/2012	47,336	03/23/2012	85,643	3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50	03/23/2012	22,010	06/22/2012	80,348	3.50
			.51					3.51
		PROVIDER TO PROGRAM	.52					3.52
			.53					3.53
			.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		25,326		5,295	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				13,441,907		3,997,924	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
			.02					5.02
			.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
			.51					5.51
			.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		414,292		238,913	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				13,856,199		4,236,837	7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [XX] IPF (14-S095) [ ] 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				2,240,091			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)				2,240,091			4
	TO BE COMPLETED BY CONTRACTOR						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER	.50		NONE		NONE	5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				2,240,091			7

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

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

CHECK APPLICABLE BOX [XX] HOSPITAL (14-0095) [ ] CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	8,943	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	7,081	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	19,069	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	295,434,832	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	21,686,480	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART II

CHECK [ ] HOSPITAL
APPLICABLE BOX: [XX] IPF (14-S095)

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS	2,485,035	1
2	NET IPF PPS OUTLIER PAYMENT	21,450	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	27.122951	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 8/LINE 9)) RAISED TO THE POWER OF .5150 -1}		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	2,506,485	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	2,506,485	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	2,506,485	18
19	DEDUCTIBLES	124,708	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	2,381,777	20
21	COINSURANCE	141,686	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	2,240,091	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	2,240,091	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	2,240,091	31
32	INTERIM PAYMENTS	2,240,091	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)		34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SNF	[XX]	PPS
	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
			[ ]	IRF	[ ]	ICF/MR	[ ]	OTHER
			[ ]	SUB (OTHER)				

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SNF	[XX]	PPS
	[XX]	TITLE XIX	[XX]	IPF (14-S095)	[ ]	NF	[ ]	TEFRA
			[ ]	IRF	[ ]	ICF/MR	[ ]	OTHER
			[ ]	SUB (OTHER)				

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

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

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			5.59	1	
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)				2	
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3.26	3	
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				3.01	
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4	
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.01	
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.02	
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			2.33	5	
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			1.78	6	
7	ENTER THE LESSER OF LINE 5 OR LINE 6			1.78	7	
		PRIMARY CARE 1	OTHER 2	TOTAL 3		
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	1.23	0.55	1.78	8	
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	1.23	0.55	1.78	9	
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10	
11	TOTAL WEIGHTED FTE COUNT	1.23	0.55		11	
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	1.22	0.52		12	
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	0.87	0.44		13	
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	1.11	0.50		14	
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15	
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16	
17	ADJUSTED ROLLING AVERAGE FTE COUNT	1.11	0.50		17	
18	PER RESIDENT AMOUNT	126,075.11	133,928.99		18	
19	APPROVED AMOUNT FOR RESIDENT COSTS	139,943	66,964	206,907	19	
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20	
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21	
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22	
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23	
24	MULTIPLY LINE 22 TIMES LINE 23				24	
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			206,907	25	
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE			
26	INPATIENT DAYS	10,267			26	
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	28,996			27	
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.354083			28	
29	PROGRAM DIRECT GME AMOUNT	73,262			29	
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30	
31	NET PROGRAM DIRECT GME AMOUNT			73,262	31	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32	
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33	
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34	
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35	
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36	
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
	PART A REASONABLE COST					
37	REASONABLE COST (SEE INSTRUCTIONS)			15,661,819	37	
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38	
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39	
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			5,424	40	
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			15,656,395	41	
	PART B REASONABLE COST					
42	REASONABLE COST (SEE INSTRUCTIONS)			5,112,089	42	
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			127	43	
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			5,111,962	44	
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			20,768,357	45	
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.753858	46	
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.246142	47	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			73,262	48	
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			55,229	49	
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			18,033	50	

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA				3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.02
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)				5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)				6
7	ENTER THE LESSER OF LINE 5 OR LINE 6				7
		PRIMARY CARE 1	OTHER 2	TOTAL 3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR				8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6				9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT				11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)				12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)				13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)				14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT				17
18	PER RESIDENT AMOUNT				18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	14,479			26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	28,996			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.499345			28
29	PROGRAM DIRECT GME AMOUNT				29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)				37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)				41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)				42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)				44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)				45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)				46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)				48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)				50

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	12,155,121				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	11,681,450				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	1,665,794				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	1,505,111				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	27,007,476				11
	FIXED ASSETS					
12	LAND	964,899				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	56,092,369				15
16	ACCUMULATED DEPRECIATION	-35,760,691				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					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)	21,296,577				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	32,944,998				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	32,944,998				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	81,249,051				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	6,143,981				37
38	SALARIES, WAGES & FEES PAYABLE					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	-753,509				43
44	OTHER CURRENT LIABILITIES	10,939,953				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	16,330,425				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	1,707,267				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	1,707,267				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	18,037,692				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	63,211,359				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)	63,211,359				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	81,249,051				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD		59,739,996							1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,707,277							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		61,447,273							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	UNRESTRICTED ASSETS	1,764,086								5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		1,764,086							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		63,211,359							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	UNRESTRICTED ASSETS									13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		63,211,359							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	28,903,621		28,903,621	1
2	SUBPROVIDER IPF	15,162,578		15,162,578	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)	44,066,199		44,066,199	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	11,401,359		11,401,359	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)	11,401,359		11,401,359	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	55,467,558		55,467,558	17
18	ANCILLARY SERVICES	99,153,965	140,813,309	239,967,274	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		37,451	37,451	27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	154,621,523	140,850,760	295,472,283	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		96,137,205	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	PHYSICIAN PRACTICE REVENUE	-22,790,215		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-22,790,215	42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		73,346,990	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	295,472,283	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	222,790,201	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	72,682,082	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	73,346,990	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-664,908	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (OTHER OPERATING REVENUE)	3,037,995	24
24.01	OTHER (PHYSICIAN REVENUE)		24.01
24.02	OTHER (RECONCILING ITEM)		24.02
24.03	OTHER (RENTAL INCOME FROM OUTSIDE CLINICS)		24.03
24.04	OTHER (STUDENT MENTORING PROGRAM)		24.04
24.05	OTHER (HOUSE STAFF/PEDS& MED STUDENT PROGR)		24.05
24.06	OTHER (FINANCIAL CENTER ,ADMINISTRATION &)		24.06
24.07	OTHER (ADMINISTRATION FHN CONTRIBUTION)		24.07
24.08	OTHER (FINANCE DEPT.)		24.08
24.09	OTHER (FQHC CLINIC SOUTH LAWNDALE)		24.09
24.10	OTHER (FQHC CLINIC LOWER WESTSIDE)		24.10
24.11	OTHER (MIDWIFERY CITY OF CHGO GRANT)		24.11
24.12	OTHER (SURGERY CAPITAL GRANT)		24.12
24.13	OTHER (QUALITY ASSURANCE)		24.13
24.14	OTHER (PROGRAM CIELO)		24.14
24.15	OTHER (51ST STREET CLINIC GRANT)		24.15
24.16	OTHER (59 TH STREET CLINIC GRANT)		24.16
24.17	OTHER (VENDING MACHINES COMMISIONS)		24.17
24.18	OTHER (LAB ADMINISTRATION)		24.18
24.19	OTHER (RADIOLOGY)		24.19
24.20	OTHER (EMERGENCY DEPARTMENT)		24.20
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	3,037,995	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,373,087	26
27	OTHER EXPENSES (NON-OPERATING INCOME)	665,810	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	665,810	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,707,277	29

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK	[ ]	TITLE V	[XX]	HOSPITAL ((14-009)	[XX]	PPS	
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
BOXES	[ ]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	703,207	1
2	CAPITAL DRG OUTLIER PAYMENTS	20,051	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	52.10	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	1.90	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0103	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	7,243	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.1481	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.5570	8
9	SUM OF LINES 7 AND 8	0.7051	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1535	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	107,942	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	838,443	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((14-009)	[XX]	PPS	
	[ ]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[XX]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES AP						21
22	I&R SRVCES-OTHER PRGM COSTS AP						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
40	SUBPROVIDER - IPF						40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MR						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
63	BLOOD STORING, PROCESSING & TR						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
75	ASC (NON-DISTINCT PART)						75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAP						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	FUND DEVELOPMENT						192.01

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204