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: 02-26-2013 TIME: 17:06_____
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 OSF HOLY FAMILY MED CTR (14-1318) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2011 AND ENDING 09/30/2012, 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		96,508	-418,218			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		146,745				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-167,101			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		243,253	-585,319			200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 WEST HARLEM AVENUE P.O.BOX: 1
2 CITY: MONMOUTH STATE: IL ZIP CODE: 61462 COUNTY: WARREN 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	OSF HOLY FAMILY MED CTR	14-1318	CABLE	1	05/01/2002	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	OSF HOLY FAMILY SWING BEDS	14-Z318	CABLE		05/01/2002	N	O	N	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	OSF HOLY FAMILY CLINICS	14-3461	CABLE		02/05/2003	N	O	N	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: 10/01/2011	TO: 09/30/2012							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.	N	N	22
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.		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.							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.			2				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.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			38

		1	2	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N	N	39

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR 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.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	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. — N — 70

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

INPATIENT REHABILITATION FACILITY PPS

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

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

LONG TERM CARE HOSPITAL PPS

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

TEFRA PROVIDERS

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

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

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

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

	PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109 IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	Y	N	Y	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.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 226,373 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.	Y	149006	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: OSF HEALTHCARE SYSTEM	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: 141318	141
142	STREET: 800 N.E. GLEN OAK AVENUE	P.O. BOX:		142
143	CITY: PEORIA	STATE: IL	ZIP CODE: 61603	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			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

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

MULTICAMPUS

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

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

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N 1	DATE 2	Y/N 3	DATE 4	
	PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	12/19/2012	Y	12/19/2012	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.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
	INTEREST EXPENSE		
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	N	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
	PURCHASED SERVICES		
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
	PROVIDER-BASED PHYSICIANS		
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	35

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: JENNIFER	LAST NAME: DAVIS	TITLE: MGR THIRD PARTY REIM 41
42	EMPLOYER: OSF HEALTHCARE SYSTEM		42
43	PHONE NUMBER: (309)655-4096	E-MAIL ADDRESS: JENNIFER.Y.DAVIS@OSFHEALTHCARE	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	23	8,418	27,466.00		884	63	1,142	1
2	HMO						22			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						576		576	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								52	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		23	8,418	27,466.00		1,460	63	1,770	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)		23	8,418	27,466.00		1,460	63	1,770	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88					7,156		36,225	26
27	TOTAL (SUM OF LINES 14-26)		23							27
28	OBSERVATION BED DAYS							26	276	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	DISCHARGES --- TITLE V	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					276	27	384	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)			138.14			276	27	384	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		33.33						26
27	TOTAL (SUM OF LINES 14-26)			171.47						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						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							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							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)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF — WORKSHEET S-7
STATISTICAL DATA

		Y/N (1)	DATE (2)	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	05/01/2002	2

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

PROSPECTIVE PAYMENT FOR SNF | WORKSHEET S-7
STATISTICAL DATA

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

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

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

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

RHC I WORKSHEET S-8

HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT NO: 14-3461

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 W. HARLEM
2 CITY: MONMOUTH STATE: ILLINOIS ZIP CODE: 61462 COUNTY: WARREN
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN

	SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
4	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)			4
5	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)			5
6	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
	0															
11	CLINIC	0700	2200	0700	2200	0700	2200	0700	2200	0700	2200	0700	2200	0700	2200	11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	N					15

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)	0.389979	1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2	NET REVENUE FROM MEDICAID	2,224,764	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	8,616,420	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	3,360,223	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.	1,135,459	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)	1,135,459	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	2,578,082	1,176,493	3,754,575	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,005,398	458,808	1,464,206	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	25,857	896,470	922,327	22
23	COST OF CHARITY CARE	979,541	-437,662	541,879	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM		24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	1,835,759	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	340,633	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	1,495,126	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	583,068	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	1,124,947	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,260,406	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		216,143	216,143	189,799	1
2	00200	CAP REL COSTS-MVBLE EQUIP				349,401	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	163,636	42,440	206,076	3,964,612	4
5	00500	ADMINISTRATIVE & GENERAL	2,334,533	3,075,271	5,409,804	-925,587	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	329,658	934,598	1,264,256	-252,772	7
8	00800	LAUNDRY & LINEN SERVICE		80,893	80,893	29,230	8
9	00900	HOUSEKEEPING	318,872	251,678	570,550	-224,079	9
10	01000	DIETARY	281,166	410,304	691,470	-178,369	10
11	01100	CAFETERIA					11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION					13
14	01400	CENTRAL SERVICES & SUPPLY					14
15	01500	PHARMACY					15
16	01600	MEDICAL RECORDS & LIBRARY	158,271	164,966	323,237	33,901	16
17	01700	SOCIAL SERVICE					17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	961,810	484,559	1,446,369	-431,908	30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	424,170	589,498	1,013,668	-495,833	50
53	05300	ANESTHESIOLOGY	286,546	87,343	373,889	-77,617	53
54	05400	RADIOLOGY-DIAGNOSTIC	461,717	445,516	907,233	-182,844	54
56	05600	RADIOISOTOPE	52,270	74,021	126,291	-68,429	56
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN		431,372	431,372	-10,888	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)		212,896	212,896	-6,395	58
60	06000	LABORATORY	402,188	798,331	1,200,519	-174,460	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY		28,174	28,174	-5,828	65
66	06600	PHYSICAL THERAPY	283,099	158,313	441,412	-125,971	66
67	06700	OCCUPATIONAL THERAPY	73,440	22,845	96,285	-20,303	67
68	06800	SPEECH PATHOLOGY		13,706	13,706		68
69	06900	ELECTROCARDIOLOGY	116,302	72,077	188,379	-61,758	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	21,375	19,658	41,033	387,304	71
72	07200	IMPL. DEV. CHARGED TO PATIENT				4,385	72
73	07300	DRUGS CHARGED TO PATIENTS	259,008	480,993	740,001	85,313	73
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					
88	08800	RURAL HEALTH CLINIC (RHC)	2,691,239	1,533,658	4,224,897	-1,207,661	88
91	09100	EMERGENCY	1,086,464	930,933	2,017,397	-285,641	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		67,500	67,500	-67,500	113
118		SUBTOTALS (SUM OF LINES 1-117)	10,705,764	11,627,686	22,333,450	240,102	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN					190
192	19200	PHYSICIANS' PRIVATE OFFICES	889,694	307,789	1,197,483	-240,102	192
200		TOTAL (SUM OF LINES 118-199)	11,595,458	11,935,475	23,530,933		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	405,942		405,942	1
2	00200	CAP REL COSTS-MVBLE EQUIP	349,401	-33,794	315,607	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	4,170,688	-159,421	4,011,267	4
5	00500	ADMINISTRATIVE & GENERAL	4,484,217	770,865	5,255,082	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,011,484	-9,589	1,001,895	7
8	00800	LAUNDRY & LINEN SERVICE	110,123		110,123	8
9	00900	HOUSEKEEPING	346,471		346,471	9
10	01000	DIETARY	513,101	-31,504	481,597	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION				13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY				15
16	01600	MEDICAL RECORDS & LIBRARY	357,138	-5,693	351,445	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,014,461		1,014,461	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	517,835		517,835	50
53	05300	ANESTHESIOLOGY	296,272	-288,156	8,116	53
54	05400	RADIOLOGY-DIAGNOSTIC	724,389		724,389	54
56	05600	RADIOISOTOPE	57,862		57,862	56
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	420,484		420,484	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	206,501	-33,494	173,007	58
60	06000	LABORATORY	1,026,059	-14,400	1,011,659	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	22,346		22,346	65
66	06600	PHYSICAL THERAPY	315,441		315,441	66
67	06700	OCCUPATIONAL THERAPY	75,982		75,982	67
68	06800	SPEECH PATHOLOGY	13,706		13,706	68
69	06900	ELECTROCARDIOLOGY	126,621		126,621	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	428,337		428,337	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	4,385		4,385	72
73	07300	DRUGS CHARGED TO PATIENTS	825,314		825,314	73
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				
88	08800	RURAL HEALTH CLINIC (RHC)	3,017,236	-12,959	3,004,277	88
91	09100	EMERGENCY	1,731,756	-785,043	946,713	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	22,573,552	-603,188	21,970,364	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	19200	PHYSICIANS' PRIVATE OFFICES	957,381		957,381	192
200		TOTAL (SUM OF LINES 118-199)	23,530,933	-603,188	22,927,745	200

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE: COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INTEREST EXPENSE	A	CAP REL COSTS-MVBLE EQUIP	2		67,500	1
500	TOTAL RECLASSIFICATIONS					67,500	500
	CODE LETTER - A						
1	MEDICAL SUPPLIES	B	MEDICAL SUPPLIES CHRGED TO PA	71		393,326	1
2			DRUGS CHARGED TO PATIENTS	73		155,611	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
500	TOTAL RECLASSIFICATIONS					548,937	500
	CODE LETTER - B						
1	RT SALARIES	C	RESPIRATORY THERAPY	65	15,898		1
2							2
500	TOTAL RECLASSIFICATIONS				15,898		500
	CODE LETTER - C						
1	A&G EXPENSES	D	MEDICAL RECORDS & LIBRARY	16	63,076		1
500	TOTAL RECLASSIFICATIONS				63,076		500
	CODE LETTER - D						
1	RHC PHYSICIAN RECRUITMENT	E	RURAL HEALTH CLINIC (RHC)	88		51,077	1
500	TOTAL RECLASSIFICATIONS					51,077	500
	CODE LETTER - E						
1	PROPERTY INSURANCE	F	CAP REL COSTS-BLDG & FIXT	1		9,666	1
2			CAP REL COSTS-MVBLE EQUIP	2		8,836	2
500	TOTAL RECLASSIFICATIONS					18,502	500
	CODE LETTER - F						
1	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	4	4,007,052		1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
500	TOTAL RECLASSIFICATIONS				4,007,052		500
	CODE LETTER - G						

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE: COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TEAM AWARD ADJ RECLASS	H	ADMINISTRATIVE & GENERAL	5	104,982		1
2			OPERATION OF PLANT	7	3,600		2
3			LAUNDRY & LINEN SERVICE	8	900		3
4			DIETARY	10	5,625		4
5			MEDICAL RECORDS & LIBRARY	16	2,700		5
6			ADULTS & PEDIATRICS	30	12,105		6
7			OPERATING ROOM	50	4,050		7
8			ANESTHESIOLOGY	53	900		8
9			RADIOLOGY-DIAGNOSTIC	54	4,545		9
10			RADIOISOTOPE	56	450		10
11			LABORATORY	60	5,265		11
12			PHYSICAL THERAPY	66	3,600		12
13			OCCUPATIONAL THERAPY	67	450		13
14			DRUGS CHARGED TO PATIENTS	73	3,240		14
15			ELECTROCARDIOLOGY	69	1,800		15
16			RURAL HEALTH CLINIC (RHC)	88	22,230		16
17			EMERGENCY	91	5,175		17
18			PHYSICIANS' PRIVATE OFFICES	192	2,700		18
500	TOTAL RECLASSIFICATIONS				184,317		500
	CODE LETTER - H						
1	DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		298,686	1
2			CAP REL COSTS-MVBLE EQUIP	2		273,065	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
500	TOTAL RECLASSIFICATIONS					571,751	500
	CODE LETTER - I						
1	LAUNDRY RECLASS	J	LAUNDRY & LINEN SERVICE	8	28,330		1
500	TOTAL RECLASSIFICATIONS				28,330		500
	CODE LETTER - J						
1	IMPLANTABLE DEVICES	K	IMPL. DEV. CHARGED TO PATIENT	72		4,385	1
500	TOTAL RECLASSIFICATIONS					4,385	500
	CODE LETTER - K						
1	CLINIC A&G	L	ADMINISTRATIVE & GENERAL	5		100,373	1
2							2
500	TOTAL RECLASSIFICATIONS					100,373	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				4,298,673	1,362,525	

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	INTEREST EXPENSE	A	INTEREST EXPENSE	113		67,500	11 1
500	TOTAL RECLASSIFICATIONS					67,500	500
	CODE LETTER - A						
1	MEDICAL SUPPLIES	B	ADULTS & PEDIATRICS	30		3,252	1
2			OPERATING ROOM	50		279,159	2
3			ANESTHESIOLOGY	53		9,413	3
4			RADIOLOGY-DIAGNOSTIC	54		1,589	4
5			RADIOISOTOPE	56		38,619	5
6			COMPUTED TOMOGRAPHY (CT) SCAN	57		6,679	6
7			MAGNETIC RESONANCE IMAGING (M	58		3,323	7
8			RESPIRATORY THERAPY	65		18,626	8
9			PHYSICAL THERAPY	66		3,434	9
10			OCCUPATIONAL THERAPY	67		696	10
11			EMERGENCY	91		5,901	11
12			RURAL HEALTH CLINIC (RHC)	88		103,818	12
13			PHYSICIANS' PRIVATE OFFICES	192		74,428	13
500	TOTAL RECLASSIFICATIONS					548,937	500
	CODE LETTER - B						
1	RT SALARIES	C	ADULTS & PEDIATRICS	30	15,571		1
2			ELECTROCARDIOLOGY	69	327		2
500	TOTAL RECLASSIFICATIONS				15,898		500
	CODE LETTER - C						
1	A&G EXPENSES	D	RURAL HEALTH CLINIC (RHC)	88	63,076		1
500	TOTAL RECLASSIFICATIONS				63,076		500
	CODE LETTER - D						
1	RHC PHYSICIAN RECRUITMENT	E	ADMINISTRATIVE & GENERAL	5		51,077	1
500	TOTAL RECLASSIFICATIONS					51,077	500
	CODE LETTER - E						
1	PROPERTY INSURANCE	F	ADMINISTRATIVE & GENERAL	5		18,502	12 1
2							12 2
500	TOTAL RECLASSIFICATIONS					18,502	500
	CODE LETTER - F						
1	EMPLOYEE BENEFIT RECLASS	G	EMPLOYEE BENEFITS	4		42,440	1
2			ADMINISTRATIVE & GENERAL	5		840,760	2
3			OPERATION OF PLANT	7		146,986	3
4			HOUSEKEEPING	9		194,165	4
5			DIETARY	10		166,524	5
6			MEDICAL RECORDS & LIBRARY	16		28,904	6
7			ADULTS & PEDIATRICS	30		390,470	7
8			OPERATING ROOM	50		158,984	8
9			ANESTHESIOLOGY	53		60,403	9
10			RADIOLOGY-DIAGNOSTIC	54		164,686	10
11			RADIOISOTOPE	56		30,171	11
12			LABORATORY	60		155,732	12
13			PHYSICAL THERAPY	66		106,157	13
14			OCCUPATIONAL THERAPY	67		20,057	14
15			DRUGS CHARGED TO PATIENTS	73		70,025	15
16			ELECTROCARDIOLOGY	69		44,064	16
17			RURAL HEALTH CLINIC (RHC)	88		989,860	17
18			EMERGENCY	91		266,823	18
19			PHYSICIANS' PRIVATE OFFICES	192		129,841	19
500	TOTAL RECLASSIFICATIONS					4,007,052	500
	CODE LETTER - G						

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	TEAM AWARD ADJ RECLASS	H	ADMINISTRATIVE & GENERAL	5		184,317	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
500	TOTAL RECLASSIFICATIONS					184,317	500
	CODE LETTER - H						
1	DEPRECIATION RECLASS	I	CAP REL COSTS-BLDG & FIXT	1		118,553	9 1
2			ADMINISTRATIVE & GENERAL	5		36,286	9 2
3			HOUSEKEEPING	9		1,584	3
4			DIETARY	10		17,470	4
5			MEDICAL RECORDS & LIBRARY	16		2,971	5
6			ADULTS & PEDIATRICS	30		34,720	6
7			OPERATING ROOM	50		57,355	7
8			ANESTHESIOLOGY	53		8,701	8
9			RADIOLOGY-DIAGNOSTIC	54		21,114	9
10			RADIOISOTOPE	56		89	10
11			COMPUTED TOMOGRAPHY (CT) SCAN	57		4,209	11
12			MAGNETIC RESONANCE IMAGING (M	58		3,072	12
13			LABORATORY	60		23,993	13
14			RESPIRATORY THERAPY	65		3,100	14
15			PHYSICAL THERAPY	66		19,980	15
16			MEDICAL SUPPLIES CHRGED TO PA	71		6,022	16
17			DRUGS CHARGED TO PATIENTS	73		3,513	17
18			ELECTROCARDIOLOGY	69		19,167	18
19			RURAL HEALTH CLINIC (RHC)	88		51,368	19
20			EMERGENCY	91		18,092	20
21			OPERATION OF PLANT	7		109,386	21
22			PHYSICIANS' PRIVATE OFFICES	192		11,006	22
500	TOTAL RECLASSIFICATIONS					571,751	500
	CODE LETTER - I						
1	LAUNDRY RECLASS	J	HOUSEKEEPING	9	28,330		1
500	TOTAL RECLASSIFICATIONS				28,330		500
	CODE LETTER - J						
1	IMPLANTABLE DEVICES	K	OPERATING ROOM	50		4,385	1
500	TOTAL RECLASSIFICATIONS					4,385	500
	CODE LETTER - K						
1	CLINIC A&G	L	RURAL HEALTH CLINIC (RHC)	88		72,846	1
2			PHYSICIANS' PRIVATE OFFICES	192		27,527	2
500	TOTAL RECLASSIFICATIONS					100,373	500
	CODE LETTER - L						
	GRAND TOTAL (DECREASES)				107,304	5,553,894	

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	325,000					325,000		1
2	LAND IMPROVEMENTS	192,152				3,705	188,447		2
3	BUILDINGS AND FIXTURES	2,746,966	861,366		861,366	755	3,607,577		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	4,297,889	852,811		852,811	59,525	5,091,175		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	7,562,007	1,714,177		1,714,177	63,985	9,212,199		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	7,562,007	1,714,177		1,714,177	63,985	9,212,199		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	216,143						216,143	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)	216,143						216,143	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	4,121,024		4,121,024	0.447344					1
2	CAP REL COSTS-MVBLE EQUIP	5,091,175		5,091,175	0.552656					2
3	TOTAL (SUM OF LINES 1-2)	9,212,199		9,212,199	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	396,276			9,666			405,942	1
2	CAP REL COSTS-MVBLE EQUIP	273,065		33,706	8,836			315,607	2
3	TOTAL	669,341		33,706	18,502			721,549	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-33,794	CAP REL COSTS-MVBLE EQUIP	2	11	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)	A	-4,610	ADMINISTRATIVE & GENERAL	5		7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-5,446	ADMINISTRATIVE & GENERAL	5		8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-799,443				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	1,201,154				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-30,560	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-5,693	MEDICAL RECORDS & LIBRARY	16		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		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	RHC OTHER INCOME	B	-12,959	RURAL HEALTH CLINIC (RHC)	88		33
33.01	MISCELLANEOUS INCOME	B	-4,525	ADMINISTRATIVE & GENERAL	5		33.01
33.02	MISCELLANEOUS INCOME	B	-944	DIETARY	10		33.02
33.03	MISCELLANEOUS INCOME	B	-9,589	OPERATION OF PLANT	7		33.03
34	MARKETING AND DEVELOPMENT SALARIES	A	-19,579	ADMINISTRATIVE & GENERAL	5		34
34.01	MARKETING & DEVELOPMENT BENEFITS	A	-5,933	EMPLOYEE BENEFITS	4		34.01
34.02	MARKETING & DEVELOPMENT OTHER	A	-35,079	ADMINISTRATIVE & GENERAL	5		34.02
34.03	FUND DEVELOPMENT SALARIES	A	-17,126	ADMINISTRATIVE & GENERAL	5		34.03
34.04	FUND DEVELOPMENT BENEFITS	A	5,823	EMPLOYEE BENEFITS	4		34.04
34.05	ADVERTISING EXPENSE	A	-157,973	ADMINISTRATIVE & GENERAL	5		34.05
35	LOBBYING	A	-10,001	ADMINISTRATIVE & GENERAL	5		35
36	CRNA SALARIES	A	-286,546	ANESTHESIOLOGY	53		36
36.01	CRNA BENEFITS	A	-60,403	EMPLOYEE BENEFITS	4		36.01
36.02	CRNA CME	A	-1,610	ANESTHESIOLOGY	53		36.02
37	ER BENEFITS	A	-98,908	EMPLOYEE BENEFITS	4		37
38	DONATIONS	A	-500	ADMINISTRATIVE & GENERAL	5		38
38.01	ALCOHOLIC BEVERAGES	A	-1,830	ADMINISTRATIVE & GENERAL	5		38.01
38.02	PROVIDER TAX IDPA	A	-199,914	ADMINISTRATIVE & GENERAL	5		38.02
38.03	CAR ALLOWANCE	A	-7,200	ADMINISTRATIVE & GENERAL	5		38.03
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48

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	
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-603,188				50

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

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

LINE NO.		COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF	
1	2	3	4	5	6	7		
1	5	ADMINISTRATIVE & GENERAL	A&G	1,484,477	600,555	883,922		1
2	5	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	350,726		350,726		2
3	5	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	28,578	28,578			3
3.01	58	MAGNETIC RESONANCE IMAGING (MRI	MOBILE MRI	188,807	212,793	-23,986		4.01
3.02	58	MAGNETIC RESONANCE IMAGING (MRI	ET MAINTENANCE AGREEMENT	134,053	143,561	-9,508		4.02
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		2,186,641	985,487	1,201,154		5

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS		
1	2	3	4	5	6		
6	B	OSF HEALTHCARE SYSTEM	100.00				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	91	EMERGENCY	EMERGENCY AGGRE	1,042,551	785,043	257,508					1
2	60	LABORATORY	LABRATORY AGGRE	14,400	14,400						2
200		TOTAL		1,056,951	799,443	257,508					200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	91	EMERGENCY	EMERGENCY AGGRE							785,043	1
2	60	LABORATORY	LABRATORY AGGRE							14,400	2
200		TOTAL								799,443	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS I & II

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	38	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	570	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	46	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE	0.35	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		317.00				9
10	AHSEA		72.77				10
11	STANDARD TRAVEL ALLOWANCE	36.39	36.39				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	23,068	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	23,068	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	23,068	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	72.77	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	41,479	22
23	TOTAL SALARY EQUIVALENCY	41,479	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS III & IV

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	1,674	24
25	ASSISTANTS		25
26	SUBTOTAL	1,674	26
27	STANDARD TRAVEL EXPENSE	16	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	1,690	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	1,690	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	41,479	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	1,690	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	43,169	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	13,119	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS I & II

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	51	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	765	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	139	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE	3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		288.50				9
10	AHSEA		66.29				10
11	STANDARD TRAVEL ALLOWANCE	33.15	33.15				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	19,125	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	19,125	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	19,125	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.29	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	50,712	22
23	TOTAL SALARY EQUIVALENCY	50,712	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS III & IV

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4,608	24
25	ASSISTANTS		25
26	SUBTOTAL	4,608	26
27	STANDARD TRAVEL EXPENSE	480	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	5,088	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	5,088	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	50,712	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	5,088	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	55,800	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	13,706	64
65	EXCESS OVER LIMITATION		65

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	405,942	405,942				1
2	CAP REL COSTS-MVBLE EQUIP	315,607		315,607			2
4	EMPLOYEE BENEFITS	4,011,267			4,011,267		4
5	ADMINISTRATIVE & GENERAL	5,255,082	37,325	29,019	895,551	6,216,977	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,001,895	93,725	72,869	122,340	1,290,829	7
8	LAUNDRY & LINEN SERVICE	110,123			10,730	120,853	8
9	HOUSEKEEPING	346,471	3,868	3,008	106,659	460,006	9
10	DIETARY	481,597	28,017	21,782	105,282	636,678	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	351,445	11,138	8,659	82,248	453,490	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	1,014,461	45,019	35,001	351,810	1,446,291	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	517,835	20,650	16,054	157,200	711,739	50
53	ANESTHESIOLOGY	8,116	981	763	330	10,190	53
54	RADIOLOGY-DIAGNOSTIC	724,389	20,675	16,074	171,166	932,304	54
56	RADIOISOTOPE	57,862			19,354	77,216	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	420,484				420,484	57
58	MAGNETIC RESONANCE IMAGING (MRI)	173,007				173,007	58
60	LABORATORY	1,011,659	8,191	6,368	149,577	1,175,795	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	22,346			5,836	28,182	65
66	PHYSICAL THERAPY	315,441	13,792	10,723	105,248	445,204	66
67	OCCUPATIONAL THERAPY	75,982	1,193	928	27,125	105,228	67
68	SPEECH PATHOLOGY	13,706	149	116		13,971	68
69	ELECTROCARDIOLOGY	126,621	5,452	4,239	43,235	179,547	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	428,337	14,981	11,647	7,847	462,812	71
72	IMPL. DEV. CHARGED TO PATIENT	4,385				4,385	72
73	DRUGS CHARGED TO PATIENTS	825,314	4,718	3,668	96,272	929,972	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	3,004,277	46,480	36,136	972,961	4,059,854	88
91	EMERGENCY	946,713	21,630	16,817	252,896	1,238,056	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	21,970,364	377,984	293,871	3,683,667	21,593,070	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,584	4,341		9,925	190
192	PHYSICIANS' PRIVATE OFFICES	957,381	22,374	17,395	327,600	1,324,750	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	22,927,745	405,942	315,607	4,011,267	22,927,745	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	6,216,977					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	480,232	1,771,061				7
8	LAUNDRY & LINEN SERVICE	44,961		165,814			8
9	HOUSEKEEPING	171,138	24,923	8,806	664,873		9
10	DIETARY	236,866	180,507		68,731	1,122,782	10
11	CAFETERIA					962,847	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	168,714	71,759		27,324		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	538,069	290,047	63,982	110,441	159,935	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	264,791	133,041	20,726	50,658		50
53	ANESTHESIOLOGY	3,791	6,320		2,406		53
54	RADIOLOGY-DIAGNOSTIC	346,849	133,205	20,343	50,720		54
56	RADIOISOTOPE	28,727					56
57	COMPUTED TOMOGRAPHY (CT) SCAN	156,434					57
58	MAGNETIC RESONANCE IMAGING (MRI)	64,364					58
60	LABORATORY	437,436	52,773	197	20,094		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	10,485					65
66	PHYSICAL THERAPY	165,631	88,858	19,655	33,834		66
67	OCCUPATIONAL THERAPY	39,148	7,688		2,927		67
68	SPEECH PATHOLOGY	5,198	958		365		68
69	ELECTROCARDIOLOGY	66,798	35,127	786	13,375		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	172,182	96,518		36,751		71
72	IMPL. DEV. CHARGED TO PATIENT	1,631					72
73	DRUGS CHARGED TO PATIENTS	345,981	30,395		11,573		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	1,510,408	299,458	3,608	114,025		88
91	EMERGENCY	460,599	139,361	26,793	53,064		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	5,720,433	1,590,938	164,896	596,288	1,122,782	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,692	35,975		13,698		190
192	PHYSICIANS' PRIVATE OFFICES	492,852	144,148	918	54,887		192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	6,216,977	1,771,061	165,814	664,873	1,122,782	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	CAFETERIA 11	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	962,847					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	45,310	766,597				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	169,540	43,202	2,821,507		2,821,507	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	54,859	60,506	1,296,320		1,296,320	50
53	ANESTHESIOLOGY	18,723	1,239	42,669		42,669	53
54	RADIOLOGY-DIAGNOSTIC	79,012	76,333	1,638,766		1,638,766	54
56	RADIOISOTOPE		12,442	118,385		118,385	56
57	COMPUTED TOMOGRAPHY (CT) SCAN		74,427	651,345		651,345	57
58	MAGNETIC RESONANCE IMAGING (MRI)		26,494	263,865		263,865	58
60	LABORATORY	77,608	153,183	1,917,086		1,917,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,932	6,880	49,479		49,479	65
66	PHYSICAL THERAPY	51,396	34,944	839,522		839,522	66
67	OCCUPATIONAL THERAPY	7,864	5,253	168,108		168,108	67
68	SPEECH PATHOLOGY		815	21,307		21,307	68
69	ELECTROCARDIOLOGY	18,442	5,669	319,744		319,744	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		45,325	813,588		813,588	71
72	IMPL. DEV. CHARGED TO PATIENT		595	6,611		6,611	72
73	DRUGS CHARGED TO PATIENTS		52,154	1,370,075		1,370,075	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	293,302	61,554	6,342,209		6,342,209	88
91	EMERGENCY	106,255	105,582	2,129,710		2,129,710	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	926,243	766,597	20,810,296		20,810,296	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			63,290		63,290	190
192	PHYSICIANS' PRIVATE OFFICES	36,604		2,054,159		2,054,159	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	962,847	766,597	22,927,745		22,927,745	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS-TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	439,827	37,325	29,019	506,171	506,171	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		93,725	72,869	166,594	39,099	7
8	LAUNDRY & LINEN SERVICE					3,661	8
9	HOUSEKEEPING		3,868	3,008	6,876	13,934	9
10	DIETARY		28,017	21,782	49,799	19,285	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		11,138	8,659	19,797	13,736	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		45,019	35,001	80,020	43,808	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		20,650	16,054	36,704	21,559	50
53	ANESTHESIOLOGY		981	763	1,744	309	53
54	RADIOLOGY-DIAGNOSTIC	98,856	20,675	16,074	135,605	28,239	54
56	RADIOISOTOPE					2,339	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	282,237			282,237	12,736	57
58	MAGNETIC RESONANCE IMAGING (MRI)					5,240	58
60	LABORATORY		8,191	6,368	14,559	35,615	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY					854	65
66	PHYSICAL THERAPY	220	13,792	10,723	24,735	13,485	66
67	OCCUPATIONAL THERAPY		1,193	928	2,121	3,187	67
68	SPEECH PATHOLOGY		149	116	265	423	68
69	ELECTROCARDIOLOGY		5,452	4,239	9,691	5,438	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		14,981	11,647	26,628	14,019	71
72	IMPL. DEV. CHARGED TO PATIENT					133	72
73	DRUGS CHARGED TO PATIENTS		4,718	3,668	8,386	28,169	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)		46,480	36,136	82,616	122,974	88
91	EMERGENCY		21,630	16,817	38,447	37,501	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	821,140	377,984	293,871	1,492,995	465,743	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,584	4,341	9,925	301	190
192	PHYSICIANS' PRIVATE OFFICES		22,374	17,395	39,769	40,127	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	821,140	405,942	315,607	1,542,689	506,171	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	205,693					7
8	LAUNDRY & LINEN SERVICE		3,661				8
9	HOUSEKEEPING	2,895	194	23,899			9
10	DIETARY	20,964		2,471	92,519		10
11	CAFETERIA				79,340	79,340	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	8,334		982		3,734	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	33,686	1,413	3,970	13,179	13,970	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	15,452	458	1,821		4,520	50
53	ANESTHESIOLOGY	734		86		1,543	53
54	RADIOLOGY-DIAGNOSTIC	15,471	449	1,823		6,511	54
56	RADIOISOTOPE						56
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MRI)						58
60	LABORATORY	6,129	4	722		6,395	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY					324	65
66	PHYSICAL THERAPY	10,320	434	1,216		4,235	66
67	OCCUPATIONAL THERAPY	893		105		648	67
68	SPEECH PATHOLOGY	111		13			68
69	ELECTROCARDIOLOGY	4,080	17	481		1,520	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	11,210		1,321			71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS	3,530		416			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	34,779	80	4,100		24,168	88
91	EMERGENCY	16,185	592	1,907		8,756	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	184,773	3,641	21,434	92,519	76,324	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,178		492			190
192	PHYSICIANS' PRIVATE OFFICES	16,742	20	1,973		3,016	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	205,693	3,661	23,899	92,519	79,340	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY	46,583				16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	2,625	192,671		192,671	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	3,677	84,191		84,191	50
53	ANESTHESIOLOGY	75	4,491		4,491	53
54	RADIOLOGY-DIAGNOSTIC	4,639	192,737		192,737	54
56	RADIOISOTOPE	756	3,095		3,095	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	4,523	299,496		299,496	57
58	MAGNETIC RESONANCE IMAGING (MRI)	1,610	6,850		6,850	58
60	LABORATORY	9,307	72,731		72,731	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	418	1,596		1,596	65
66	PHYSICAL THERAPY	2,123	56,548		56,548	66
67	OCCUPATIONAL THERAPY	319	7,273		7,273	67
68	SPEECH PATHOLOGY	50	862		862	68
69	ELECTROCARDIOLOGY	345	21,572		21,572	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	2,754	55,932		55,932	71
72	IMPL. DEV. CHARGED TO PATIENT	36	169		169	72
73	DRUGS CHARGED TO PATIENTS	3,169	43,670		43,670	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC (RHC)	3,741	272,458		272,458	88
91	EMERGENCY	6,416	109,804		109,804	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
113	INTEREST EXPENSE					113
118	SUBTOTALS (SUM OF LINES 1-117)	46,583	1,426,146		1,426,146	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		14,896		14,896	190
192	PHYSICIANS' PRIVATE OFFICES		101,647		101,647	192
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	46,583	1,542,689		1,542,689	202

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	95,600					1
2	CAP REL COSTS-MVBLE EQUIP		95,600				2
4	EMPLOYEE BENEFITS			10,926,852			4
5	ADMINISTRATIVE & GENERAL	8,790	8,790	2,439,515	-6,216,977	16,710,768	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	22,073	22,073	333,258		1,290,829	7
8	LAUNDRY & LINEN SERVICE			29,230		120,853	8
9	HOUSEKEEPING	911	911	290,542		460,006	9
10	DIETARY	6,598	6,598	286,791		636,678	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	2,623	2,623	224,047		453,490	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	10,602	10,602	958,344		1,446,291	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,863	4,863	428,220		711,739	50
53	ANESTHESIOLOGY	231	231	900		10,190	53
54	RADIOLOGY-DIAGNOSTIC	4,869	4,869	466,262		932,304	54
56	RADIOISOTOPE			52,720		77,216	56
57	COMPUTED TOMOGRAPHY (CT) SCAN					420,484	57
58	MAGNETIC RESONANCE IMAGING (MRI)					173,007	58
60	LABORATORY	1,929	1,929	407,453		1,175,795	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			15,898		28,182	65
66	PHYSICAL THERAPY	3,248	3,248	286,699		445,204	66
67	OCCUPATIONAL THERAPY	281	281	73,890		105,228	67
68	SPEECH PATHOLOGY	35	35			13,971	68
69	ELECTROCARDIOLOGY	1,284	1,284	117,775		179,547	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	3,528	3,528	21,375		462,812	71
72	IMPL. DEV. CHARGED TO PATIENT					4,385	72
73	DRUGS CHARGED TO PATIENTS	1,111	1,111	262,248		929,972	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	10,946	10,946	2,650,393		4,059,854	88
91	EMERGENCY	5,094	5,094	688,898		1,238,056	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	89,016	89,016	10,034,458	-6,216,977	15,376,093	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315	1,315			9,925	190
192	PHYSICIANS' PRIVATE OFFICES	5,269	5,269	892,394		1,324,750	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	405,942	315,607	4,011,267		6,216,977	202
203	UNIT COST MULT-WS B PT I	4.246255	3.301328	0.367102		0.372034	203
204	COST TO BE ALLOC PER B PT II					506,171	204
205	UNIT COST MULT-WS B PT II					0.030290	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	FTE'S	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	64,737					7
8	LAUNDRY & LINEN SERVICE		116,174				8
9	HOUSEKEEPING	911	6,170	63,826			9
10	DIETARY	6,598		6,598	47,871		10
11	CAFETERIA				41,052	10,285	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	2,623		2,623		484	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	10,602	44,827	10,602	6,819	1,811	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,863	14,521	4,863		586	50
53	ANESTHESIOLOGY	231		231		200	53
54	RADIOLOGY-DIAGNOSTIC	4,869	14,253	4,869		844	54
56	RADIOISOTOPE						56
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MRI)						58
60	LABORATORY	1,929	138	1,929		829	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY					42	65
66	PHYSICAL THERAPY	3,248	13,771	3,248		549	66
67	OCCUPATIONAL THERAPY	281		281		84	67
68	SPEECH PATHOLOGY	35		35			68
69	ELECTROCARDIOLOGY	1,284	551	1,284		197	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	3,528		3,528			71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS	1,111		1,111			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	10,946	2,528	10,946		3,133	88
91	EMERGENCY	5,094	18,772	5,094		1,135	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	58,153	115,531	57,242	47,871	9,894	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315		1,315			190
192	PHYSICIANS' PRIVATE OFFICES	5,269	643	5,269		391	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,771,061	165,814	664,873	1,122,782	962,847	202
203	UNIT COST MULT-WS B PT I	27.357786	1.427290	10.416962	23.454325	93.616626	203
204	COST TO BE ALLOC PER B PT II	205,693	3,661	23,899	92,519	79,340	204
205	UNIT COST MULT-WS B PT II	3.177364	0.031513	0.374440	1.932673	7.714147	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	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	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY	53,362,666	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	3,007,220	30
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	4,211,777	50
53	ANESTHESIOLOGY	86,217	53
54	RADIOLOGY-DIAGNOSTIC	5,313,451	54
56	RADIOISOTOPE	866,046	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	5,180,794	57
58	MAGNETIC RESONANCE IMAGING (MRI)	1,844,208	58
60	LABORATORY	10,663,566	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	478,932	65
66	PHYSICAL THERAPY	2,432,385	66
67	OCCUPATIONAL THERAPY	365,682	67
68	SPEECH PATHOLOGY	56,761	68
69	ELECTROCARDIOLOGY	394,638	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	3,155,008	71
72	IMPL. DEV. CHARGED TO PATIENT	41,450	72
73	DRUGS CHARGED TO PATIENTS	3,630,370	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
88	RURAL HEALTH CLINIC (RHC)	4,284,706	88
91	EMERGENCY	7,349,455	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	53,362,666	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192	PHYSICIANS' PRIVATE OFFICES		192
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	766,597	202
203	UNIT COST MULT-WS B PT I	0.014366	203
204	COST TO BE ALLOC PER B PT II	46,583	204
205	UNIT COST MULT-WS B PT II	0.000873	205

COMPUTATION OF RATIO OF COST TO CHARGES — WORKSHEET C PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,821,507		2,821,507		2,821,507	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,296,320		1,296,320		1,296,320	50
53	ANESTHESIOLOGY	42,669		42,669		42,669	53
54	RADIOLOGY-DIAGNOSTIC	1,638,766		1,638,766		1,638,766	54
56	RADIOISOTOPE	118,385		118,385		118,385	56
57	COMPUTED TOMOGRAPHY (CT) SC	651,345		651,345		651,345	57
58	MAGNETIC RESONANCE IMAGING	263,865		263,865		263,865	58
60	LABORATORY	1,917,086		1,917,086		1,917,086	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	49,479		49,479		49,479	65
66	PHYSICAL THERAPY	839,522		839,522		839,522	66
67	OCCUPATIONAL THERAPY	168,108		168,108		168,108	67
68	SPEECH PATHOLOGY	21,307		21,307		21,307	68
69	ELECTROCARDIOLOGY	319,744		319,744		319,744	69
71	MEDICAL SUPPLIES CHRGED TO	813,588		813,588		813,588	71
72	IMPL. DEV. CHARGED TO PATIE	6,611		6,611		6,611	72
73	DRUGS CHARGED TO PATIENTS	1,370,075		1,370,075		1,370,075	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	6,342,209		6,342,209		6,342,209	88
91	EMERGENCY	2,129,710		2,129,710		2,129,710	91
92	OBSERVATION BEDS	389,693		389,693		389,693	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	21,199,989		21,199,989		21,199,989	200
201	LESS OBSERVATION BEDS	389,693		389,693		389,693	201
202	TOTAL (SEE INSTRUCTIONS)	20,810,296		20,810,296		20,810,296	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	2,665,912		2,665,912				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	805,543	3,406,234	4,211,777	0.307785	0.307785	0.307785	50
53	ANESTHESIOLOGY	513	85,705	86,218	0.494897	0.494897	0.494897	53
54	RADIOLOGY-DIAGNOSTIC	336,620	4,976,830	5,313,450	0.308418	0.308418	0.308418	54
56	RADIOISOTOPE	18,264	847,782	866,046	0.136696	0.136696	0.136696	56
57	COMPUTED TOMOGRAPHY (CT) SC	336,028	4,844,766	5,180,794	0.125723	0.125723	0.125723	57
58	MAGNETIC RESONANCE IMAGING	15,458	1,828,750	1,844,208	0.143078	0.143078	0.143078	58
60	LABORATORY	1,022,663	9,640,903	10,663,566	0.179779	0.179779	0.179779	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	364,433	114,499	478,932	0.103311	0.103311	0.103311	65
66	PHYSICAL THERAPY	261,045	2,171,339	2,432,384	0.345144	0.345144	0.345144	66
67	OCCUPATIONAL THERAPY	134,448	231,234	365,682	0.459711	0.459711	0.459711	67
68	SPEECH PATHOLOGY	22,454	34,307	56,761	0.375381	0.375381	0.375381	68
69	ELECTROCARDIOLOGY	1,603	393,035	394,638	0.810221	0.810221	0.810221	69
71	MEDICAL SUPPLIES CHRGED TO	739,483	2,415,525	3,155,008	0.257872	0.257872	0.257872	71
72	IMPL. DEV. CHARGED TO PATIE		41,450	41,450	0.159493	0.159493	0.159493	72
73	DRUGS CHARGED TO PATIENTS	1,736,706	1,893,665	3,630,371	0.377393	0.377393	0.377393	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)		4,284,706	4,284,706				88
91	EMERGENCY	426,342	6,923,113	7,349,455	0.289778	0.289778	0.289778	91
92	OBSERVATION BEDS		341,256	341,256	1.141937	1.141937	1.141937	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	8,887,515	44,475,099	53,362,614				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	8,887,515	44,475,099	53,362,614				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1318)	[ ]	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	0.307785		965,415			297,140		50
53	ANESTHESIOLOGY	0.494897		48,529			24,017		53
54	RADIOLOGY-DIAGNOSTIC	0.308418		1,488,572			459,102		54
56	RADIOISOTOPE	0.136696		327,685			44,793		56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723		1,767,529			222,219		57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078		439,021			62,814		58
60	LABORATORY	0.179779		4,132,959			743,019		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.103311		52,190			5,392		65
66	PHYSICAL THERAPY	0.345144		666,967			230,200		66
67	OCCUPATIONAL THERAPY	0.459711		67,977			31,250		67
68	SPEECH PATHOLOGY	0.375381		21,038			7,897		68
69	ELECTROCARDIOLOGY	0.810221		112,032			90,771		69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872		704,955			181,788		71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493		29,219			4,660		72
73	DRUGS CHARGED TO PATIENTS	0.377393		697,652	433		263,289	163	73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
91	EMERGENCY	0.289778		2,096,322			607,468		91
92	OBSERVATION BEDS	1.141937		216,290			246,990		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			13,834,352	433		3,522,809	163	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			13,834,352	433		3,522,809	163	202

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B-SNF (14-Z318)
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	0.307785							50
53	ANESTHESIOLOGY	0.494897							53
54	RADIOLOGY-DIAGNOSTIC	0.308418							54
56	RADIOISOTOPE	0.136696							56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078							58
60	LABORATORY	0.179779							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.103311							65
66	PHYSICAL THERAPY	0.345144							66
67	OCCUPATIONAL THERAPY	0.459711							67
68	SPEECH PATHOLOGY	0.375381							68
69	ELECTROCARDIOLOGY	0.810221							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872							71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493							72
73	DRUGS CHARGED TO PATIENTS	0.377393							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
91	EMERGENCY	0.289778							91
92	OBSERVATION BEDS	1.141937							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	192,671	55,954	136,717	1,418	96.42	63	6,074	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	192,671		136,717	1,418		63	6,074	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	84,191	4,211,777	0.019989			50
53	ANESTHESIOLOGY	4,491	86,218	0.052089			53
54	RADIOLOGY-DIAGNOSTIC	192,737	5,313,450	0.036273			54
56	RADIOISOTOPE	3,095	866,046	0.003574			56
57	COMPUTED TOMOGRAPHY (CT) SCAN	299,496	5,180,794	0.057809			57
58	MAGNETIC RESONANCE IMAGING (M	6,850	1,844,208	0.003714			58
60	LABORATORY	72,731	10,663,566	0.006821			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	1,596	478,932	0.003332			65
66	PHYSICAL THERAPY	56,548	2,432,384	0.023248			66
67	OCCUPATIONAL THERAPY	7,273	365,682	0.019889			67
68	SPEECH PATHOLOGY	862	56,761	0.015186			68
69	ELECTROCARDIOLOGY	21,572	394,638	0.054663			69
71	MEDICAL SUPPLIES CHRGED TO PA	55,932	3,155,008	0.017728			71
72	IMPL. DEV. CHARGED TO PATIENT	169	41,450	0.004077			72
73	DRUGS CHARGED TO PATIENTS	43,670	3,630,371	0.012029			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)	272,458	4,284,706	0.063588			88
91	EMERGENCY	109,804	7,349,455	0.014940			91
92	OBSERVATION BEDS	37,502	341,256	0.109894			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	1,270,977	50,696,702				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	1,418		63		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)	1,418		63		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	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
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
56	RADIOISOTOPE							56
57	COMPUTED TOMOGRAPHY (CT) SCAN							57
58	MAGNETIC RESONANCE IMAGING (M							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHRGED TO PA							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)							88
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 (14-1318)	[ ]	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	4,211,777							50
53	ANESTHESIOLOGY	86,218							53
54	RADIOLOGY-DIAGNOSTIC	5,313,450							54
56	RADIOISOTOPE	866,046							56
57	COMPUTED TOMOGRAPHY (CT) SCA	5,180,794							57
58	MAGNETIC RESONANCE IMAGING (	1,844,208							58
60	LABORATORY	10,663,566							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	478,932							65
66	PHYSICAL THERAPY	2,432,384							66
67	OCCUPATIONAL THERAPY	365,682							67
68	SPEECH PATHOLOGY	56,761							68
69	ELECTROCARDIOLOGY	394,638							69
71	MEDICAL SUPPLIES CHRGED TO P	3,155,008							71
72	IMPL. DEV. CHARGED TO PATIEN	41,450							72
73	DRUGS CHARGED TO PATIENTS	3,630,371							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)	4,284,706							88
91	EMERGENCY	7,349,455							91
92	OBSERVATION BEDS	341,256							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	50,696,702							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ]	S/B-SNF
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES - PPS REIMBURSED SERVICES	PROGRAM CHARGES - COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES - COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS - PPS SERVICES	PROGRAM COSTS - COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS - COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.307785							50
53	ANESTHESIOLOGY	0.494897							53
54	RADIOLOGY-DIAGNOSTIC	0.308418							54
56	RADIOISOTOPE	0.136696							56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723							57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078							58
60	LABORATORY	0.179779							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.103311							65
66	PHYSICAL THERAPY	0.345144							66
67	OCCUPATIONAL THERAPY	0.459711							67
68	SPEECH PATHOLOGY	0.375381							68
69	ELECTROCARDIOLOGY	0.810221							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872							71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493							72
73	DRUGS CHARGED TO PATIENTS	0.377393							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC (RHC)								88
91	EMERGENCY	0.289778							91
92	OBSERVATION BEDS	1.141937							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 (14-1318)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	2,046	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,418	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,142	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	144	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)	432	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13	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)	39	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	884	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)	144	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)	432	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	117.79	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.79	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,821,507	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)	1,531	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	4,594	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	819,397	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,002,110	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,626,930	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,626,930	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.230606	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)	1,424.63	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)	2,002,110	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,411.93	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,248,146	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)	1,248,146	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					808,019	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,056,165	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)		50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST		52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY 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)	203,318	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)	609,954	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)	813,272	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)	276	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,411.93	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	389,693	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	192,671	2,002,110	0.096234	389,693	37,502	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1318)	[ ]	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)	2,046	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,418	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,142	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	144	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)	432	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	13	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)	39	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	63	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	117.79	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.79	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,821,507	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)	1,531	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	4,594	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	819,397	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,002,110	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,626,930	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,626,930	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.230606	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)	1,424.63	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)	2,002,110	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1318)	[ ]	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)	1,411.93	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	88,952	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)	88,952	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					88,952	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					6,074	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					6,074	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					82,878	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)	276	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,220,496		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.307785	390,372	120,151	50
53	ANESTHESIOLOGY	0.494897	125	62	53
54	RADIOLOGY-DIAGNOSTIC	0.308418	202,496	62,453	54
56	RADIOISOTOPE	0.136696	10,566	1,444	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723	63,467	7,979	57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078	11,143	1,594	58
60	LABORATORY	0.179779	532,366	95,708	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.103311	240,899	24,888	65
66	PHYSICAL THERAPY	0.345144	60,971	21,044	66
67	OCCUPATIONAL THERAPY	0.459711	18,444	8,479	67
68	SPEECH PATHOLOGY	0.375381	14,760	5,541	68
69	ELECTROCARDIOLOGY	0.810221	1,005	814	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872	392,241	101,148	71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493			72
73	DRUGS CHARGED TO PATIENTS	0.377393	941,189	355,198	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
91	EMERGENCY	0.289778	5,232	1,516	91
92	OBSERVATION BEDS	1.141937			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		2,885,276	808,019	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		2,885,276		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z318)	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.307785			50
53	ANESTHESIOLOGY	0.494897			53
54	RADIOLOGY-DIAGNOSTIC	0.308418	24,943	7,693	54
56	RADIOISOTOPE	0.136696	2,239	306	56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723	8,828	1,110	57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078	3,565	510	58
60	LABORATORY	0.179779	111,044	19,963	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.103311	49,713	5,136	65
66	PHYSICAL THERAPY	0.345144	179,634	62,000	66
67	OCCUPATIONAL THERAPY	0.459711	104,242	47,921	67
68	SPEECH PATHOLOGY	0.375381	5,238	1,966	68
69	ELECTROCARDIOLOGY	0.810221			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872	43,299	11,166	71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493			72
73	DRUGS CHARGED TO PATIENTS	0.377393	347,854	131,278	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
91	EMERGENCY	0.289778			91
92	OBSERVATION BEDS	1.141937			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		880,599	289,049	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		880,599		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.307785			50
53	ANESTHESIOLOGY	0.494897			53
54	RADIOLOGY-DIAGNOSTIC	0.308418			54
56	RADIOISOTOPE	0.136696			56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.125723			57
58	MAGNETIC RESONANCE IMAGING (MRI	0.143078			58
60	LABORATORY	0.179779			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.103311			65
66	PHYSICAL THERAPY	0.345144			66
67	OCCUPATIONAL THERAPY	0.459711			67
68	SPEECH PATHOLOGY	0.375381			68
69	ELECTROCARDIOLOGY	0.810221			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.257872			71
72	IMPL. DEV. CHARGED TO PATIENT	0.159493			72
73	DRUGS CHARGED TO PATIENTS	0.377393			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC (RHC)				88
91	EMERGENCY	0.289778			91
92	OBSERVATION BEDS	1.141937			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1318) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,522,972	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)	3,522,972	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)		17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	3,558,202	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)	27,278	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,981,333	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	1,549,591	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	1,549,591	30
31	PRIMARY PAYER PAYMENTS	344	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	1,549,247	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)	314,961	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	314,961	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	1,864,208	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	1,864,208	40
41	INTERIM PAYMENTS	2,282,426	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-418,218	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	51,032	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 (14-1318) [ ] 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				1,694,952		2,361,425	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	05/11/2012	67,787	05/11/2011		3.01
		.02	09/21/2011	28,276	09/21/2011	71,619	3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE	05/11/2012	150,618	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		96,063		-78,999	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)				1,791,015		2,282,426	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		96,508			6.01
	PROVIDER TO PROGRAM	.02				-418,218	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,887,523		1,864,208	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 [ ] IPF [ ] IRF [XX] SUB (OTHER) SNF SWING BED SNF (14-Z318)

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				950,257			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	05/11/2011	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	3.50
		.51	05/11/2011	1,619			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		-1,619			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)				948,638			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		146,745			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,095,383			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 (14-1318) [ ] 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	384	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	884	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	22	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,142	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	53,362,614	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,754,575	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS WORKSHEET E-2

CHECK	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z318)	
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF	
BOXES	[ ]	TITLE XIX			

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	821,405		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)			2
3	ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	291,939		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	576		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	1,113,344		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	1,113,344		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	1,113,344		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	17,961		13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,095,383		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,095,383		19
20	INTERIM PAYMENTS	948,638		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	146,745		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	9,719		23

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART V

CHECK [XX] HOSPITAL (14-1318)
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	2,056,165	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,056,165	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	2,076,727	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	2,076,727	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	214,876	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,861,851	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,861,851	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	25,672	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	25,672	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	25,672	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,887,523	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,887,523	30
31	INTERIM PAYMENTS	1,791,015	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	96,508	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	18,124	34

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[XX]	HOSPITAL (14-1318)	[ ]	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)			15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)			18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)			27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)			30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)			42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	5,732,937				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,748,874				4
5	OTHER RECEIVABLES	615,030				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	597,925				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	883,606				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	12,578,372				11
	FIXED ASSETS					
12	LAND	325,000				12
13	LAND IMPROVEMENTS	188,447				13
14	ACCUMULATED DEPRECIATION	-132,778				14
15	BUILDINGS	3,607,577				15
16	ACCUMULATED DEPRECIATION	-1,847,434				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	5,091,175				23
24	ACCUMULATED DEPRECIATION	-2,979,554				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)	4,252,433				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	11,627,317				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	11,627,317				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	28,458,122				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	766,323				37
38	SALARIES, WAGES & FEES PAYABLE	1,807,681				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	1,164,784				43
44	OTHER CURRENT LIABILITIES	2,699,455				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,438,243				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	171,400				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	171,400				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	6,609,643				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,848,479				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)	21,848,479				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	28,458,122				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD		19,010,179							1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		2,734,510							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		21,744,689							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	CONTRIBUTIONS	710								5
6	CONTRIBUTIONS RELEASED	103,080								6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		103,790							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		21,848,479							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	CONTRIBUTIONS RELEASED									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)		21,848,479							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	1,626,930		1,626,930	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	513,194		513,194	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)	2,140,124		2,140,124	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,140,124		2,140,124	17
18	ANCILLARY SERVICES	5,866,974		5,866,974	18
19	OUTPATIENT SERVICES		47,508,442	47,508,442	19
20	RHC		4,284,706	4,284,706	20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	8,007,098	51,793,148	59,800,246	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		23,530,933	29
30	ADD (SPECIFY)			30
31	BAD DEBTS			31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		23,530,933	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	59,800,246	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	33,932,678	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,867,568	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	23,530,933	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	2,336,635	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	75,965	6
7	INCOME FROM INVESTMENTS	33,833	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	29,469	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		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	4,342	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GRANT INCOME)	215,305	24
24.01	OTHER (GAIN ON DISPOSAL)	4,159	24.01
24.02	OTHER (OTHER REVENUE)	34,802	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	397,875	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,734,510	26
27	OTHER EXPENSES (SALE OF ASSETS)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,734,510	29

CALCULATION OF CAPITAL PAYMENT — WORKSHEET L

CHECK	[ ]	TITLE V	[XX]	HOSPITAL ((14-131)	[XX]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
BOXES	[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	EXTRAORDINARY 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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES 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
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
56	RADIOISOTOPE						56
57	COMPUTED TOMOGRAPHY (CT) SCAN						57
58	MAGNETIC RESONANCE IMAGING (MR						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PAT						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC (RHC)						88
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
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

RHC I WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT NO: 14-3461

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	1,476,799	31,427	1,508,226		1,508,226		1,508,226	1
2	PHYSICIAN ASSISTANT	470,036		470,036		470,036		470,036	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE	681,329		681,329		681,329		681,329	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (SUM OF LINES 1-9)	2,628,164	31,427	2,659,591		2,659,591		2,659,591	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		133,665	133,665	-103,818	29,847		29,847	15
16	TRANSPORTATION (HEALTH CARE STAFF)		3,347	3,347		3,347		3,347	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE		48,968	48,968		48,968		48,968	18
19	OTHER HEALTH CARE COSTS		157,107	157,107		157,107		157,107	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		343,087	343,087	-103,818	239,269		239,269	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,628,164	374,514	3,002,678	-103,818	2,898,860		2,898,860	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	63,076	1,159,144	1,222,220	-1,103,844	118,376	-12,959	105,417	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	63,076	1,159,144	1,222,220	-1,103,844	118,376	-12,959	105,417	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	2,691,240	1,533,658	4,224,898	-1,207,662	3,017,236	-12,959	3,004,277	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | COMPONENT NO: 14-3461

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
		1	2	3	4	5	
1	PHYSICIANS	4.91	18,546	4,200	20,622		1
2	PHYSICIAN ASSISTANTS	3.76	13,896	2,100	7,896		2
3	NURSE PRACTITIONERS	0.82	2,591	2,100	1,722		3
4	SUBTOTAL (SUM OF LINES 1-3)	9.49	35,033		30,240	35,033	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER	0.88	1,192			1,192	7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	10.37	36,225			36,225	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)	2,898,860	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	2,898,860	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)	105,417	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	3,337,932	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	3,443,349	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)		17
18	SUBTRACT LINE 17 FROM LINE 16	3,443,349	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)	3,443,349	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	6,342,209	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3461

CHECK APPLICABLE BOXES: [XX] RHC [ ] FQHC [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	6,342,209	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	31,183	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	6,311,026	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	36,225	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	36,225	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	174.22	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	78.07	78.54		8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	174.22	174.22	174.22	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)				10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)				11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	1,789	5,367		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	311,680	935,039		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	214,280	701,279		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)				15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)		915,559		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)		961,263		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		7,980		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		7,601		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)		657,184		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)		664,785		16.05
17	PRIMARY PAYOR PAYMENTS		1,065		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR		86,478		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		173,958		19
20	NET MEDICARE COST EXCUDING VACCINES (SEE INSTRUCTIONS)		663,720		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		26,853		21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		690,573		22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)				25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		690,573		26
27	INTERIM PAYMENTS		857,674		27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)				28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		-167,101		29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3461

CHECK APPLICABLE BOXES: [XX] RHC [ ] FQHC [ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1	HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	2,659,591	2,659,591	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000170	0.000800	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	452	2,128	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	5,960	5,712	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	6,412	7,840	5
6	TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,898,860	2,898,860	6
7	TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	3,443,349	3,443,349	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002212	0.002705	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	7,617	9,314	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	14,029	17,154	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	105	516	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	133.61	33.24	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	95	426	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	12,693	14,160	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		31,183	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		26,853	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I COMPONENT NO: 14-3461

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [ ] FQHC

	DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				750,739	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	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	05/11/2012	74,129	3.01
			.02	09/21/2011	32,806	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	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		106,935	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)				857,674	4
		TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE	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	5.50
		TO	.51			5.51
		PROGRAM	.52			5.52
			.53			5.53
			.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99			5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02		-167,101	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				690,573	7

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