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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11-27-2012 TIME: 11:43_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [ ] 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 LINDEN OAKS HOSPITAL (14-4035) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		54,597				1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		54,597				200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1	STREET: 852 WEST STREET	P.O.BOX:		1
2	CITY: NAPERVILLE STATE: IL	ZIP CODE: 60540	COUNTY: DUPAGE	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	LINDEN OAKS HOSPITAL	14-4035	16980	4	06/01/1992	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2011	TO: 06/30/2012							20
21	TYPE OF CONTROL		2							21

INPATIENT PPS INFORMATION

		1	2	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILTY SUBJECT TO 42 CFR §412.06(c)(2)(PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.	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.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:			ENDING:		38

		V 1	XVIII 2	XIX 3	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL					
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	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.				Y	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				N N	71
INPATIENT REHABILITATION FACILITY PPS						
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.					76
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				N	80
TEFRA PROVIDERS						
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.				N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				N	86
					V XIX	
TITLE V AND XIX INPATIENT SERVICES					1 2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.				N Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.				N N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.					97
RURAL PROVIDERS					1 2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?				N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.					106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.					107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.				N	108
			PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		N	N	N	N	109

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

MISCELLANEOUS COST REPORTING INFORMATION

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

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y		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: EDWARD HEALTH SERVICES CORPORA CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES, CONTRACTOR'S NUMBER: 00131		141
142	STREET: 801 SOUTH WASHINGTON STREET P.O. BOX:		142
143	CITY: NAPERVILLE, ILLINOIS 60540 STATE: ZIP CODE:		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)	N	N			158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161

MULTICAMPUS

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

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

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

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

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

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

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

		Y/N 1	Y/N 2	
APPROVED EDUCATIONAL ACTIVITIES				
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	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)	Y	10/11/2012	N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	10/11/2012	N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	35

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME:	LAST NAME:	TITLE:	41
42	EMPLOYER:			42
43	PHONE NUMBER:	E-MAIL ADDRESS:		43

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

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	110	40,260			4,738	2,470	29,760	1
2	HMO									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		110	40,260			4,738	2,470	29,760	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)		110	40,260			4,738	2,470	29,760	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		110							27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

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

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					430	292	3,885	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)			498.00			430	292	3,885	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			498.00						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	18,960,911					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		4,309,242					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		892,140					38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY		211,464					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)	18,960,911	18,960,911	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	18,960,911	18,960,911	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)	18,960,911	18,960,911	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,412,846	5,412,846	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

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				787,266	1
2	00200	CAP REL COSTS-MVBLE EQUIP				149,730	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS		2,849,197	2,849,197	1,372,392	4
5	00500	ADMINISTRATIVE & GENERAL	4,309,242	7,952,698	12,261,940	-1,221,331	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT		575,640	575,640	-19,933	7
8	00800	LAUNDRY & LINEN SERVICE					8
9	00900	HOUSEKEEPING					9
10	01000	DIETARY		876,599	876,599		10
11	01100	CAFETERIA					11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	892,140	78,548	970,688	-63,448	13
14	01400	CENTRAL SERVICES & SUPPLY					14
15	01500	PHARMACY	211,464	685,384	896,848	-496,586	15
16	01600	MEDICAL RECORDS & LIBRARY					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	9,289,105	1,031,102	10,320,207	-1,464,586	30
		ANCILLARY SERVICE COST CENTERS					
54	05400	RADIOLOGY-DIAGNOSTIC		332,446	332,446		54
60	06000	LABORATORY		267,146	267,146		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66	06600	PHYSICAL THERAPY	150,847	46,125	196,972	-11,343	66
69	06900	ELECTROCARDIOLOGY		32,879	32,879		69
70	07000	ELECTROENCEPHALOGRAPHY		2,288	2,288		70
73	07300	DRUGS CHARGED TO PATIENTS				496,586	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					
90.01	09001	PARTIAL HOSPITALIZATION	4,108,113	1,021,711	5,129,824	471,253	90.01
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF					99.10
99.20	09920	OPT					99.20
99.30	09930	CMHC					99.30
99.40	09940	OPT					99.40
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	18,960,911	15,751,763	34,712,674		118
		NONREIMBURSABLE COST CENTERS					
194	07950	EDWARD ACADEMY					194
200		TOTAL (SUM OF LINES 118-199)	18,960,911	15,751,763	34,712,674		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	787,266		787,266	1
2	00200	CAP REL COSTS-MVBLE EQUIP	149,730		149,730	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	4,221,589	47,524	4,269,113	4
5	00500	ADMINISTRATIVE & GENERAL	11,040,609	1,480,571	12,521,180	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	555,707		555,707	7
8	00800	LAUNDRY & LINEN SERVICE		43,141	43,141	8
9	00900	HOUSEKEEPING		535,889	535,889	9
10	01000	DIETARY	876,599		876,599	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	907,240	-580,597	326,643	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	400,262		400,262	15
16	01600	MEDICAL RECORDS & LIBRARY				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	8,855,621	1,638	8,857,259	30
		ANCILLARY SERVICE COST CENTERS				
54	05400	RADIOLOGY-DIAGNOSTIC	332,446		332,446	54
60	06000	LABORATORY	267,146		267,146	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	06600	PHYSICAL THERAPY	185,629		185,629	66
69	06900	ELECTROCARDIOLOGY	32,879		32,879	69
70	07000	ELECTROENCEPHALOGRAPHY	2,288		2,288	70
73	07300	DRUGS CHARGED TO PATIENTS	496,586		496,586	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				
90.01	09001	PARTIAL HOSPITALIZATION	5,601,077	-98,255	5,502,822	90.01
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF				99.10
99.20	09920	OPT				99.20
99.30	09930	CMHC				99.30
99.40	09940	OPT				99.40
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	34,712,674	1,429,911	36,142,585	118
		NONREIMBURSABLE COST CENTERS				
194	07950	EDWARD ACADEMY				194
200		TOTAL (SUM OF LINES 118-199)	34,712,674	1,429,911	36,142,585	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	INCREASE LINE #	INCREASE SALARY	INCREASE OTHER	
		1	2	3	4	5	
1	RENT & LEASE EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		38,091	1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					38,091	500
	CODE LETTER - A						
1	PROPERTY INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1		27,392	1
500	TOTAL RECLASSIFICATIONS					27,392	500
	CODE LETTER - B						
1	BENEFIT AND FICA RECLASS	C	EMPLOYEE BENEFITS	4		1,372,392	1
2							2
3							3
4							4
5							5
6							6
500	TOTAL RECLASSIFICATIONS					1,372,392	500
	CODE LETTER - C						
1	DEPRECIATION EXPENSE	D	CAP REL COSTS-BLDG & FIXT	1		717,212	1
2			CAP REL COSTS-MVBLE EQUIP	2		149,730	2
500	TOTAL RECLASSIFICATIONS					866,942	500
	CODE LETTER - D						
1	REAL ESTATE TAXES	E	CAP REL COSTS-BLDG & FIXT	1		4,571	1
500	TOTAL RECLASSIFICATIONS					4,571	500
	CODE LETTER - E						
1	PARTIAL HOSPITALIZATION	F	PARTIAL HOSPITALIZATION	90.01	678,434	93,770	1
500	TOTAL RECLASSIFICATIONS				678,434	93,770	500
	CODE LETTER - F						
1	RECLASS DRUGS CHARGED TO PATIENTS	G	DRUGS CHARGED TO PATIENTS	73		496,586	1
500	TOTAL RECLASSIFICATIONS					496,586	500
	CODE LETTER - G						
	GRAND TOTAL (INCREASES)				678,434	2,899,744	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RENT & LEASE EXPENSE	A					9	1
2			ADMINISTRATIVE & GENERAL	5		8,524		2
3			OPERATION OF PLANT	7		19,933		3
4			NURSING ADMINISTRATION	13		1,733		4
5			ADULTS & PEDIATRICS	30		3,840		5
6			PARTIAL HOSPITALIZATION	90.01		4,061		6
500	TOTAL RECLASSIFICATIONS					38,091		500
	CODE LETTER - A							
1	PROPERTY INSURANCE	B	ADMINISTRATIVE & GENERAL	5		27,392	9	1
500	TOTAL RECLASSIFICATIONS					27,392		500
	CODE LETTER - B							
1	BENEFIT AND FICA RECLASS	C						1
2			ADMINISTRATIVE & GENERAL	5		313,902		2
3			NURSING ADMINISTRATION	13		61,715		3
4			ADULTS & PEDIATRICS	30		688,542		4
5			PHYSICAL THERAPY	66		11,343		5
6			PARTIAL HOSPITALIZATION	90.01		296,890		6
500	TOTAL RECLASSIFICATIONS					1,372,392		500
	CODE LETTER - C							
1	DEPRECIATION EXPENSE	D	ADMINISTRATIVE & GENERAL	5		866,942	9	1
2							9	2
500	TOTAL RECLASSIFICATIONS					866,942		500
	CODE LETTER - D							
1	REAL ESTATE TAXES	E	ADMINISTRATIVE & GENERAL	5		4,571	9	1
500	TOTAL RECLASSIFICATIONS					4,571		500
	CODE LETTER - E							
1	PARTIAL HOSPITALIZATION	F	ADULTS & PEDIATRICS	30	678,434	93,770		1
500	TOTAL RECLASSIFICATIONS				678,434	93,770		500
	CODE LETTER - F							
1	RECLASS DRUGS CHARGED TO PATIENTS	G	PHARMACY	15		496,586		1
500	TOTAL RECLASSIFICATIONS					496,586		500
	CODE LETTER - G							
	GRAND TOTAL (DECREASES)				678,434	2,899,744		

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES (1)	ACQUISITIONS: PURCHASE (2)	ACQUISITIONS: DONATION (3)	ACQUISITIONS: TOTAL (4)	DISPOSALS AND RETIREMENTS (5)	ENDING BALANCE (6)	FULLY DEPRECIATED ASSETS (7)	
1	LAND								1
2	LAND IMPROVEMENTS	485,306	494,281		494,281		979,587		2
3	BUILDINGS AND FIXTURES	9,165,011	4,039,424		4,039,424		13,204,435		3
4	BUILDING IMPROVEMENTS	4,154,102	1,608,019		1,608,019		5,762,121		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	1,881,953	265,293		265,293		2,147,246		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	15,686,372	6,407,017		6,407,017		22,093,389		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	15,686,372	6,407,017		6,407,017		22,093,389		10

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

SUMMARY OF CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(1) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT								1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)								3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

	DESCRIPTION	GROSS ASSETS (1)	CAPITALIZED LEASES (2)	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) (3)	RATIO (SEE INSTR.) (4)	
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
3	TOTAL (SUM OF LINES 1-2)					3

ALLOCATION OF OTHER CAPITAL

	DESCRIPTION	INSURANCE (5)	TAXES (6)	OTHER CAPITAL-RELATED COSTS (7)	TOTAL (SUM OF COLS. 5-7) (8)	
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
3	TOTAL (SUM OF LINES 1-2)					3

SUMMARY OF CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(2) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	787,266						787,266	1
2	CAP REL COSTS-MVBLE EQUIP	149,730						149,730	2
3	TOTAL	936,996						936,996	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED: COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,594				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	2,851,404				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		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	OTHER REVENUE	B	-459,728	ADMINISTRATIVE & GENERAL	5		33
34	OTHER REVENUE	B	-580,597	NURSING ADMINISTRATION	13		34
35	OTHER REVENUE	B	-9,605	ADULTS & PEDIATRICS	30		35
36	OTHER REVENUE	B	-10,200	PARTIAL HOSPITALIZATION	90.01		36
37	PHP MEALS EXPENSE	A	-88,055	PARTIAL HOSPITALIZATION	90.01		37
38							38
39							39
40							40
41							41
42	CONTRIBUTIONS EXPENSE	A	-2,000	ADMINISTRATIVE & GENERAL	5		42
43	MARKETING	A	-269,714	ADMINISTRATIVE & GENERAL	5		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		1,429,911				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	HOME OFFICE COSTS	3,666,715	1,996,091	1,670,624		1
2								2
3	4	EMPLOYEE BENEFITS	EDWARD HOSPITAL BENEFITS	47,524		47,524		3
4	8	LAUNDRY & LINEN SERVICE	EH LAUNDRY & LINEN	43,141		43,141		4
4.01	9	HOUSEKEEPING	EH HOUSEKEEPING	535,889		535,889		4.01
4.02	30	ADULTS & PEDIATRICS	EH EMT TRAINING	11,243		11,243		4.02
4.04	5	ADMINISTRATIVE & GENERAL	PATIENT ACCOUNTING	340,396		340,396		4.04
4.05	5	ADMINISTRATIVE & GENERAL	PATIENT ACCESS	168,106		168,106		4.05
4.06	5	ADMINISTRATIVE & GENERAL	MEDICAL STAFF	34,481		34,481		4.06
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		4,847,495	1,996,091	2,851,404		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	EDWARD HEALTH SERVIC				MANAGEMANET	6
7	B	EDWARD HOSPITAL				HEALTHCARE	7
8							8
9							9
10							10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	5	ADMINISTRATIVE & GENERAL ADMIN AND GENER	155,694		155,694	154,100	2,080	154,100	7,705	1
200		TOTAL	155,694		155,694		2,080	154,100	7,705	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	5	ADMINISTRATIVE & GENERAL ADMIN AND GENER					154,100	1,594	1,594	1
200		TOTAL					154,100	1,594	1,594	200

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	787,266	787,266				1
2	CAP REL COSTS-MVBLE EQUIP	149,730		149,730			2
4	EMPLOYEE BENEFITS	4,269,113			4,269,113		4
5	ADMINISTRATIVE & GENERAL	12,521,180	45,399	8,634	970,239	13,545,452	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	555,707	424,333	80,705		1,060,745	7
8	LAUNDRY & LINEN SERVICE	43,141				43,141	8
9	HOUSEKEEPING	535,889				535,889	9
10	DIETARY	876,599	26,970	5,129		908,698	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	326,643			200,868	527,511	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	400,262	2,350	447	47,612	450,671	15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,857,259	220,991	42,030	1,938,725	11,059,005	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	332,446				332,446	54
60	LABORATORY	267,146	1,673	318		269,137	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	185,629			33,964	219,593	66
69	ELECTROCARDIOLOGY	32,879				32,879	69
70	ELECTROENCEPHALOGRAPHY	2,288				2,288	70
73	DRUGS CHARGED TO PATIENTS	496,586				496,586	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	5,502,822	65,550	12,467	1,077,705	6,658,544	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	36,142,585	787,266	149,730	4,269,113	36,142,585	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	36,142,585	787,266	149,730	4,269,113	36,142,585	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL	13,545,452					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	635,844	1,696,589				7
8	LAUNDRY & LINEN SERVICE	25,860		69,001			8
9	HOUSEKEEPING	321,229		9,000	866,118		9
10	DIETARY	544,703	144,102	13,200	73,565	1,684,268	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	316,207					13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	270,147	12,555		6,409		15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	6,629,128	1,180,758	46,801	602,783	1,684,268	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	199,279					54
60	LABORATORY	161,329	8,941		4,565		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY	131,631					66
69	ELECTROCARDIOLOGY	19,709					69
70	ELECTROENCEPHALOGRAPHY	1,372					70
73	DRUGS CHARGED TO PATIENTS	297,670					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	3,991,344	350,233		178,796		90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	13,545,452	1,696,589	69,001	866,118	1,684,268	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	13,545,452	1,696,589	69,001	866,118	1,684,268	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION	PHARMACY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		13	15	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	843,718					13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		739,782				15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	637,570		21,840,313		21,840,313	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC			531,725		531,725	54
60	LABORATORY			443,972		443,972	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY			351,224		351,224	66
69	ELECTROCARDIOLOGY			52,588		52,588	69
70	ELECTROENCEPHALOGRAPHY			3,660		3,660	70
73	DRUGS CHARGED TO PATIENTS		739,782	1,534,038		1,534,038	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	206,148		11,385,065		11,385,065	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	843,718	739,782	36,142,585		36,142,585	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	843,718	739,782	36,142,585		36,142,585	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		45,399	8,634	54,033	54,033	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		424,333	80,705	505,038	2,536	7
8	LAUNDRY & LINEN SERVICE					103	8
9	HOUSEKEEPING					1,281	9
10	DIETARY		26,970	5,129	32,099	2,173	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION					1,261	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		2,350	447	2,797	1,078	15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		220,991	42,030	263,021	26,445	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC					795	54
60	LABORATORY		1,673	318	1,991	644	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY					525	66
69	ELECTROCARDIOLOGY					79	69
70	ELECTROENCEPHALOGRAPHY					5	70
73	DRUGS CHARGED TO PATIENTS					1,187	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION		65,550	12,467	78,017	15,921	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		787,266	149,730	936,996	54,033	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		787,266	149,730	936,996	54,033	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	
		7	8	9	10	13	
	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	507,574					7
8	LAUNDRY & LINEN SERVICE		103				8
9	HOUSEKEEPING		13	1,294			9
10	DIETARY	43,111	20	110	77,513		10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION					1,261	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	3,756		10			15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	353,252	70	900	77,513	953	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY	2,675		7			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
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						
90.01	PARTIAL HOSPITALIZATION	104,780		267		308	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	507,574	103	1,294	77,513	1,261	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	507,574	103	1,294	77,513	1,261	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	PHARMACY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	24	25	26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY	7,641				15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS		722,154		722,154	30
	ANCILLARY SERVICE COST CENTERS					
54	RADIOLOGY-DIAGNOSTIC		795		795	54
60	LABORATORY		5,317		5,317	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
66	PHYSICAL THERAPY		525		525	66
69	ELECTROCARDIOLOGY		79		79	69
70	ELECTROENCEPHALOGRAPHY		5		5	70
73	DRUGS CHARGED TO PATIENTS	7,641	8,828		8,828	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	PARTIAL HOSPITALIZATION		199,293		199,293	90.01
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OPT					99.20
99.30	CMHC					99.30
99.40	OPT					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	7,641	936,996		936,996	118
	NONREIMBURSABLE COST CENTERS					
194	EDWARD ACADEMY					194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	7,641	936,996		936,996	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	112,908					1
2	CAP REL COSTS-MVBLE EQUIP		112,908				2
4	EMPLOYEE BENEFITS			18,960,911			4
5	ADMINISTRATIVE & GENERAL	6,511	6,511	4,309,242	-13,545,452	22,597,133	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	60,857	60,857			1,060,745	7
8	LAUNDRY & LINEN SERVICE					43,141	8
9	HOUSEKEEPING					535,889	9
10	DIETARY	3,868	3,868			908,698	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION			892,140		527,511	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	337	337	211,464		450,671	15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	31,694	31,694	8,610,671		11,059,005	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC					332,446	54
60	LABORATORY	240	240			269,137	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY			150,847		219,593	66
69	ELECTROCARDIOLOGY					32,879	69
70	ELECTROENCEPHALOGRAPHY					2,288	70
73	DRUGS CHARGED TO PATIENTS					496,586	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	9,401	9,401	4,786,547		6,658,544	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	112,908	112,908	18,960,911	-13,545,452	22,597,133	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	787,266	149,730	4,269,113		13,545,452	202
203	UNIT COST MULT-WS B PT I	6.972633	1.326124	0.225153		0.599432	203
204	COST TO BE ALLOC PER B PT II					54,033	204
205	UNIT COST MULT-WS B PT II					0.002391	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY PATIENT DAYS 10	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	
	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	45,540					7
8	LAUNDRY & LINEN SERVICE		575				8
9	HOUSEKEEPING		75	45,540			9
10	DIETARY	3,868	110	3,868	100		10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION					367,580	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	337		337			15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	31,694	390	31,694	100	277,768	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY	240		240			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
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						
90.01	PARTIAL HOSPITALIZATION	9,401		9,401		89,812	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	45,540	575	45,540	100	367,580	118
	NONREIMBURSABLE COST CENTERS						
194	EDWARD ACADEMY						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,696,589	69,001	866,118	1,684,268	843,718	202
203	UNIT COST MULT-WS B PT I	37.254919	120.001739	19.018841	16,842.680000	2.295332	203
204	COST TO BE ALLOC PER B PT II	507,574	103	1,294	77,513	1,261	204
205	UNIT COST MULT-WS B PT II	11.145674	0.179130	0.028415	775.130000	0.003431	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	PHARMACY COSTED REQUIS. 15	
	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	100	15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS		30
	ANCILLARY SERVICE COST CENTERS		
54	RADIOLOGY-DIAGNOSTIC		54
60	LABORATORY		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
66	PHYSICAL THERAPY		66
69	ELECTROCARDIOLOGY		69
70	ELECTROENCEPHALOGRAPHY		70
73	DRUGS CHARGED TO PATIENTS	100	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90.01	PARTIAL HOSPITALIZATION		90.01
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OPT		99.20
99.30	CMHC		99.30
99.40	OPT		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	100	118
	NONREIMBURSABLE COST CENTERS		
194	EDWARD ACADEMY		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	739,782	202
203	UNIT COST MULT-WS B PT I	7,397.820000	203
204	COST TO BE ALLOC PER B PT II	7,641	204
205	UNIT COST MULT-WS B PT II	76.410000	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	21,840,313		21,840,313		21,840,313	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	531,725		531,725		531,725	54
60	LABORATORY	443,972		443,972		443,972	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
66	PHYSICAL THERAPY	351,224		351,224		351,224	66
69	ELECTROCARDIOLOGY	52,588		52,588		52,588	69
70	ELECTROENCEPHALOGRAPHY	3,660		3,660		3,660	70
73	DRUGS CHARGED TO PATIENTS	1,534,038		1,534,038		1,534,038	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	11,385,065		11,385,065		11,385,065	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OPT						99.20
99.30	CMHC						99.30
99.40	OPT						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	36,142,585		36,142,585		36,142,585	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	36,142,585		36,142,585		36,142,585	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	46,128,375		46,128,375				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC	1,029,383		1,029,383	0.516547	0.516547	0.516547	54
60	LABORATORY	5,848,086	1,613	5,849,699	0.075897	0.075897	0.075897	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
66	PHYSICAL THERAPY	22,303		22,303	15.747837	15.747837	15.747837	66
69	ELECTROCARDIOLOGY	345,281		345,281	0.152305	0.152305	0.152305	69
70	ELECTROENCEPHALOGRAPHY	7,112		7,112	0.514623	0.514623	0.514623	70
73	DRUGS CHARGED TO PATIENTS	4,337,869	312	4,338,181	0.353613	0.353613	0.353613	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	PARTIAL HOSPITALIZATION	4,504,028	31,030,843	35,534,871	0.320391	0.320391	0.320391	90.01
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OPT							99.20
99.30	CMHC							99.30
99.40	OPT							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	62,222,437	31,032,768	93,255,205				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	62,222,437	31,032,768	93,255,205				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	722,154		722,154	29,760	24.27	4,738	114,991	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)	722,154		722,154	29,760		4,738	114,991	200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	795	1,029,383	0.000772	244,854	189	54
60	LABORATORY	5,317	5,849,699	0.000909	780,091	709	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
66	PHYSICAL THERAPY	525	22,303	0.023539	5,531	130	66
69	ELECTROCARDIOLOGY	79	345,281	0.000229	51,043	12	69
70	ELECTROENCEPHALOGRAPHY	5	7,112	0.000703	2,762	2	70
73	DRUGS CHARGED TO PATIENTS	8,828	4,338,181	0.002035	1,241,446	2,526	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	199,293	35,534,871	0.005608	279,962	1,570	90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	214,842	47,126,830		2,605,689	5,138	200

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

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

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

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

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

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
	INPAT ROUTINE SERV COST CTRS					
30	ADULTS & PEDIATRICS	29,760		4,738		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)	29,760		4,738		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
90.01	PARTIAL HOSPITALIZATION							90.01
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	1,029,383			244,854				54
60	LABORATORY	5,849,699			780,091				60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
66	PHYSICAL THERAPY	22,303			5,531				66
69	ELECTROCARDIOLOGY	345,281			51,043				69
70	ELECTROENCEPHALOGRAPHY	7,112			2,762				70
73	DRUGS CHARGED TO PATIENTS	4,338,181			1,241,446				73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PARTIAL HOSPITALIZATION	35,534,871			279,962				90.01
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	47,126,830			2,605,689				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	S/B-SNF	
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF	
BOXES	[ ]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.516547							54
60	LABORATORY	0.075897							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	15.747837							66
69	ELECTROCARDIOLOGY	0.152305							69
70	ELECTROENCEPHALOGRAPHY	0.514623							70
73	DRUGS CHARGED TO PATIENTS	0.353613							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PARTIAL HOSPITALIZATION	0.320391							90.01
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

CHECK [ ] TITLE V
APPLICABLE [ ] TITLE XVIII-PT A
BOXES [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	722,154		722,154	29,760	24.27	2,470	59,947	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)	722,154		722,154	29,760		2,470	59,947	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC	795	1,029,383	0.000772			54
60	LABORATORY	5,317	5,849,699	0.000909			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
66	PHYSICAL THERAPY	525	22,303	0.023539			66
69	ELECTROCARDIOLOGY	79	345,281	0.000229			69
70	ELECTROENCEPHALOGRAPHY	5	7,112	0.000703			70
73	DRUGS CHARGED TO PATIENTS	8,828	4,338,181	0.002035			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	PARTIAL HOSPITALIZATION	199,293	35,534,871	0.005608			90.01
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	214,842	47,126,830				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	29,760		2,470		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)	29,760		2,470		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
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							
90.01	PARTIAL HOSPITALIZATION							90.01
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
	[ ] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[XX] TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	1,029,383							54
60	LABORATORY	5,849,699							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
66	PHYSICAL THERAPY	22,303							66
69	ELECTROCARDIOLOGY	345,281							69
70	ELECTROENCEPHALOGRAPHY	7,112							70
73	DRUGS CHARGED TO PATIENTS	4,338,181							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PARTIAL HOSPITALIZATION	35,534,871							90.01
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	47,126,830							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	S/B-SNF	
APPLICABLE	[ ]	TITLE XVIII-PT B	[ ]	IPF	[ ]	SNF	[ ]	S/B-NF	
BOXES	[XX]	TITLE XIX - O/P	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES: PPS REIMBURSED SERVICES	PROGRAM CHARGES: COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES: COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS: PPS SERVICES	PROGRAM COSTS: COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS: COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC	0.516547							54
60	LABORATORY	0.075897							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
66	PHYSICAL THERAPY	15.747837							66
69	ELECTROCARDIOLOGY	0.152305							69
70	ELECTROENCEPHALOGRAPHY	0.514623							70
73	DRUGS CHARGED TO PATIENTS	0.353613							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	PARTIAL HOSPITALIZATION	0.320391							90.01
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	29,760	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,760	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,760	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,738	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	21,840,313	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	21,840,313	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	50,626,518	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	50,626,518	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.431401	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)	1,701.16	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)	21,840,313	37

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

CHECK	[ ] TITLE V-INPT	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ] TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	733.88	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,477,123	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	3,477,123	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)					810,670	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,287,793	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					114,991	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					5,138	51
52	TOTAL PROGRAM EXCLUDABLE COST					120,129	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					4,167,664	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)		87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	733.88	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	29,760	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,760	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,760	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,470	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	21,840,313	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	21,840,313	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	50,626,518	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	50,626,518	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.431401	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)	1,701.16	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)	21,840,313	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	733.88	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	1,812,684	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)	1,812,684	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)					1,812,684	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					59,947	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					59,947	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)						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)		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 (14-4035)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		8,874,222		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.516547	244,854	126,479	54
60	LABORATORY	0.075897	780,091	59,207	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	15.747837	5,531	87,101	66
69	ELECTROCARDIOLOGY	0.152305	51,043	7,774	69
70	ELECTROENCEPHALOGRAPHY	0.514623	2,762	1,421	70
73	DRUGS CHARGED TO PATIENTS	0.353613	1,241,446	438,991	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PARTIAL HOSPITALIZATION	0.320391	279,962	89,697	90.01
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		2,605,689	810,670	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		2,605,689		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC	0.516547			54
60	LABORATORY	0.075897			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
66	PHYSICAL THERAPY	15.747837			66
69	ELECTROCARDIOLOGY	0.152305			69
70	ELECTROENCEPHALOGRAPHY	0.514623			70
73	DRUGS CHARGED TO PATIENTS	0.353613			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	PARTIAL HOSPITALIZATION	0.320391			90.01
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-4035) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

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

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

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-4035) [ ] 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				4,004,659			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					3.01
		.02					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		NONE	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					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)				4,004,659			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		54,597			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				4,059,256			7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART II

CHECK [XX] HOSPITAL (14-4035)
APPLICABLE BOX: [ ] IPF

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS	4,279,508	1
2	NET IPF PPS OUTLIER PAYMENT	68,118	2
3	NET IPF PPS ECT PAYMENT	42,088	3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	81.311475	9
10	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 8/LINE 9)) RAISED TO THE POWER OF .5150 -1}		10
11	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	4,389,714	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	4,389,714	16
17	PRIMARY PAYER PAYMENTS	30,781	17
18	SUBTOTAL (LINE 16 LESS LINE 17)	4,358,933	18
19	DEDUCTIBLES	309,844	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	4,049,089	20
21	COINSURANCE	44,429	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	4,004,660	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	77,994	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	54,596	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	4,059,256	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	4,059,256	31
32	INTERIM PAYMENTS	4,004,659	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS THE SUM OF LINES 32 AND 33)	54,597	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[XX]	HOSPITAL (14-4035)	[ ]	SNF	[ ]	PPS
	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
			[ ]	IRF	[ ]	ICF/MR	[XX]	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	1,812,684		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	1,812,684		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	1,812,684		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)	1,812,684		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	18,185,114				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	6,046,128				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	127,392				7
8	PREPAID EXPENSES	103,030				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	24,461,664				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS	979,587				13
14	ACCUMULATED DEPRECIATION	-400,000				14
15	BUILDINGS	19,031,803				15
16	ACCUMULATED DEPRECIATION	-7,200,000				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	2,147,246				23
24	ACCUMULATED DEPRECIATION	-1,735,689				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)	12,822,947				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	280,076				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	280,076				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	37,564,687				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE					37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	6,625,486				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,625,486				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)					50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	6,625,486				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	30,939,201				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)	30,939,201				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	37,564,687				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD		22,767,724							1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		5,019,772							2
3	TOTAL (SUM OF LINE 1 AND LINE 2)		27,787,496							3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	RESTRICTED NET ASSETS	3,151,705								5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)		3,151,705							10
11	SUBTOTAL (LINE 3 PLUS LINE 10)		30,939,201							11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	CHANGES IN RESTR NET ASSETS									13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		30,939,201							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	46,128,375		46,128,375	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	46,128,375		46,128,375	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)	46,128,375		46,128,375	17
18	ANCILLARY SERVICES	16,094,062	31,032,768	47,126,830	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	62,222,437	31,032,768	93,255,205	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		34,712,674	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38	OP REFERRALS			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)		34,712,674	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	93,255,205	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	56,106,597	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	37,148,608	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	34,712,674	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	2,435,934	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24			24
24.01	OTHER (EDUCATION REVENUE)		24.01
24.02	OTHER (NURSE TRIAGE SERVICES)		24.02
24.03	OTHER (OTHER MISCELLANEOUS OPERATING REVEN)	2,607,173	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,607,173	25
26	TOTAL (LINE 5 PLUS LINE 25)	5,043,107	26
27	OTHER EXPENSES (NON OPERATING INCOME)	23,335	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	23,335	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	5,019,772	29