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: 10-25-2012 TIME: 10:37_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY THE REHABILITATION INSTITUTE OF ST LOUIS (26-3028) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 06/01/2011 AND ENDING 05/31/2012, 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		151,732			-132,813	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		151,732			-132,813	200

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 4455 DUNCAN AVENUE P.O.BOX: 1
2 CITY: ST LOUIS STATE: MO ZIP CODE: 63110 COUNTY: ST LOUIS 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	THE REHABILITATION INSTITUTE	26-3028	41180	5	04/02/2001	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: 06/01/2011		TO: 05/31/2012						20
21	TYPE OF CONTROL			5						21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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.	6,301	281	1,515	195		672	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.				N	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.					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.				Y	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.				Y N	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.		Y	Y	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.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 102,244 PAID LOSSES: 1,239,032 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	019005	140

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

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

144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	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	DATE		
	PROVIDER ORGANIZATION AND OPERATION	1	2		
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	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y			3

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	1	2	3	
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	Y/N	
	APPROVED EDUCATIONAL ACTIVITIES	1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		Y	08/17/2012	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	08/17/2012	N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS: SPLIT UB CODES INVOLVED IN SUA SITUA	Y		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

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

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: JIM	LAST NAME: WYATT	TITLE: REIMBURSEMENT SPECIA	41
42	EMPLOYER: HEALTHSOUTH CORPORATION			42
43	PHONE NUMBER: 205-969-8265	E-MAIL ADDRESS: JAMES.WYATT@HEALTHSOUTH.COM		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	96	35,136			10,860	6,191	29,174	1
2	HMO						1,399	2,773		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.)		96	35,136			10,860	6,191	29,174	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)		96	35,136			10,860	6,191	29,174	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)		96							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					866	425	1,943	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		5.62	329.16			866	425	1,943	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)		5.62	329.16						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	17,126,400			684,652.80		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)			46,864		2,398.58		10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		392,098			9,179.00		11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		283,929			2,129.00		13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,708,590			22,363.77		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)		2,477,701					17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		6,798					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		2,746,932	-12,532		101,379.20		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		6,056			15.20		28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		248,334			12,251.20		30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		310,136			26,790.40		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		544,672			38,792.00		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		617,436			19,094.40		38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		221,235			10,961.60		41
42	SOCIAL SERVICE		484,652			17,118.40		42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	17,132,456		17,132,456	684,668.00	25.02	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		46,864	46,864	2,398.58	19.54	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	17,132,456	-46,864	17,085,592	682,269.42	25.04	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,384,617		2,384,617	33,671.77	70.82	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,477,701		2,477,701		14.50%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	21,994,774	-46,864	21,947,910	715,941.19	30.66	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	5,179,453	-12,532	5,166,921	226,402.40	22.82	7

HOSPITAL WAGE RELATED COSTS — WORKSHEET S-3 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	229,537	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)	1,119,879	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	38,119	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	325,902	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	1,258,612	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	130,545	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	-618,094	22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,484,500	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	CONTRACT LABOR	BENEFIT COST	
	0	1	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		1,393,567	1,393,567	126,056	1
2	00200	CAP REL COSTS-MVBLE EQUIP		588,821	588,821	25,588	2
3	00300	OTHER CAPITAL RELATED COSTS		118,895	118,895	-118,895	3
4	00400	EMPLOYEE BENEFITS		3,341,354	3,341,354	-160	4
5	00500	ADMINISTRATIVE & GENERAL	2,746,932	4,283,516	7,030,448	-662,329	5
7	00700	OPERATION OF PLANT	248,334	786,985	1,035,319	118,514	7
8	00800	LAUNDRY & LINEN SERVICE		187,632	187,632		8
9	00900	HOUSEKEEPING	310,136	93,860	403,996		9
10	01000	DIETARY	544,672	635,185	1,179,857	-26	10
11	01100	CAFETERIA					11
13	01300	NURSING ADMINISTRATION	617,436	9,433	626,869		13
16	01600	MEDICAL RECORDS & LIBRARY	221,235	20,000	241,235		16
17	01700	SOCIAL SERVICE	484,652	8,059	492,711		17
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				165,000	21
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	5,632,423	464,028	6,096,451	239,333	30
		ANCILLARY SERVICE COST CENTERS					
54	05400	RADIOLOGY-DIAGNOSTIC		323,903	323,903	-323,903	54
54.01	05401	RADIOLOGY SUA				323,945	54.01
60	06000	LABORATORY		364,535	364,535	-364,535	60
60.01	06001	LAB SUA				364,695	60.01
65	06500	RESPIRATORY THERAPY	376,582	826	377,408	4,281	65
66	06600	PHYSICAL THERAPY	2,593,415	82,257	2,675,672		66
67	06700	OCCUPATIONAL THERAPY	2,115,374	69,746	2,185,120		67
68	06800	SPEECH PATHOLOGY	767,519	13,165	780,684		68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	75,157	700,309	775,466		71
73	07300	DRUGS CHARGED TO PATIENTS	358,201	1,049,970	1,408,171		73
76	03550	PSYCHOLOGY	34,332	517	34,849	-34,849	76
		OUTPATIENT SERVICE COST CENTERS					
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		217,266	217,266		113
118		SUBTOTALS (SUM OF LINES 1-117)	17,126,400	14,753,829	31,880,229	-137,285	118
		NONREIMBURSABLE COST CENTERS					
192	19200	PHYSICIANS' PRIVATE OFFICES		42	42	-42	192
194	07950	MARKETING				12,715	194
194.01	07951	GUEST MEALS					194.01
194.02	07952	CLINICAL PSYCH				124,612	194.02
200		TOTAL (SUM OF LINES 118-199)	17,126,400	14,753,871	31,880,271		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
		GENERAL SERVICE COST CENTERS				
1	00100	CAP REL COSTS-BLDG & FIXT	1,519,623	80,321	1,599,944	1
2	00200	CAP REL COSTS-MVBLE EQUIP	614,409	-27,610	586,799	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	3,341,194	-874,715	2,466,479	4
5	00500	ADMINISTRATIVE & GENERAL	6,368,119	2,420,675	8,788,794	5
7	00700	OPERATION OF PLANT	1,153,833	-238,987	914,846	7
8	00800	LAUNDRY & LINEN SERVICE	187,632		187,632	8
9	00900	HOUSEKEEPING	403,996	65	404,061	9
10	01000	DIETARY	1,179,831	56	1,179,887	10
11	01100	CAFETERIA				11
13	01300	NURSING ADMINISTRATION	626,869	-1,638	625,231	13
16	01600	MEDICAL RECORDS & LIBRARY	241,235	45	241,280	16
17	01700	SOCIAL SERVICE	492,711	-110	492,601	17
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD	165,000		165,000	21
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	6,335,784	-19,964	6,315,820	30
		ANCILLARY SERVICE COST CENTERS				
54	05400	RADIOLOGY-DIAGNOSTIC				54
54.01	05401	RADIOLOGY SUA	323,945	-22,374	301,571	54.01
60	06000	LABORATORY				60
60.01	06001	LAB SUA	364,695		364,695	60.01
65	06500	RESPIRATORY THERAPY	381,689	7,065	388,754	65
66	06600	PHYSICAL THERAPY	2,675,672	227	2,675,899	66
67	06700	OCCUPATIONAL THERAPY	2,185,120	16,645	2,201,765	67
68	06800	SPEECH PATHOLOGY	780,684	-15	780,669	68
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	775,466	243	775,709	71
73	07300	DRUGS CHARGED TO PATIENTS	1,408,171	501	1,408,672	73
76	03550	PSYCHOLOGY				76
		OUTPATIENT SERVICE COST CENTERS				
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE	217,266	-217,266		113
118		SUBTOTALS (SUM OF LINES 1-117)	31,742,944	1,123,164	32,866,108	118
		NONREIMBURSABLE COST CENTERS				
192	19200	PHYSICIANS' PRIVATE OFFICES				192
194	07950	MARKETING	12,715		12,715	194
194.01	07951	GUEST MEALS				194.01
194.02	07952	CLINICAL PSYCH	124,612		124,612	194.02
200		TOTAL (SUM OF LINES 118-199)	31,880,271	1,123,164	33,003,435	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INSURANCE	A	CAP REL COSTS-BLDG & FIXT	1		27,223	1
2	INSURANCE	A	CAP REL COSTS-MVBLE EQUIP	2		5,526	2
3	INSURANCE	A					3
500	TOTAL RECLASSIFICATIONS					32,749	500
	CODE LETTER - A						
1	MARKETING	B	MARKETING	194	12,532	183	1
2	MARKETING	B					2
3	MARKETING	B					3
500	TOTAL RECLASSIFICATIONS				12,532	183	500
	CODE LETTER - B						
1	PHYSICIANS	C	ADULTS & PEDIATRICS	30		239,333	1
2	PHYSICIANS	C					2
500	TOTAL RECLASSIFICATIONS					239,333	500
	CODE LETTER - C						
1	MISC RECLASS	D	RESPIRATORY THERAPY	65		4,281	1
2	MISC RECLASS	D					2
500	TOTAL RECLASSIFICATIONS					4,281	500
	CODE LETTER - D						
1	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY SUA	54.01		323,903	1
2	SERVICE UNDER ARRANGEMENT	E	LAB SUA	60.01		364,535	2
3	SERVICE UNDER ARRANGEMENT	E					3
4	SERVICE UNDER ARRANGEMENT	E					4
500	TOTAL RECLASSIFICATIONS					688,438	500
	CODE LETTER - E						
1	CLINICAL PSYCHOLOGY	F	CLINICAL PSYCH	194.02	34,332	43,606	1
2	CLINICAL PSYCHOLOGY	F					2
3	CLINICAL PSYCHOLOGY	F					3
500	TOTAL RECLASSIFICATIONS				34,332	43,606	500
	CODE LETTER - F						
1	CONTRACT SERVICES RECLASS	G	CLINICAL PSYCH	194.02		46,674	1
2	CONTRACT SERVICES RECLASS	G					2
500	TOTAL RECLASSIFICATIONS					46,674	500
	CODE LETTER - G						
1	PROFESSIONAL FEES	H	I&R SRVCES-SALARY & FRINGES A	21		165,000	1
2	PROFESSIONAL FEES	H					2
500	TOTAL RECLASSIFICATIONS					165,000	500
	CODE LETTER - H						
1	BARNES JEWISH RECLASS	I	OPERATION OF PLANT	7		122,795	1
2	BARNES JEWISH RECLASS	I	RADIOLOGY SUA	54.01		42	2
3	BARNES JEWISH RECLASS	I	LAB SUA	60.01		160	3
4	BARNES JEWISH RECLASS	I					4
5	BARNES JEWISH RECLASS	I					5
6	BARNES JEWISH RECLASS	I					6
500	TOTAL RECLASSIFICATIONS					122,997	500
	CODE LETTER - I						
	GRAND TOTAL (INCREASES)				46,864	1,343,261	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INSURANCE	A					12	1
2	INSURANCE	A					12	2
3	INSURANCE	A	ADMINISTRATIVE & GENERAL	5		32,749		3
500	TOTAL RECLASSIFICATIONS					32,749		500
	CODE LETTER - A							
1	MARKETING	B						1
2	MARKETING	B	ADMINISTRATIVE & GENERAL	5	12,532	157		2
3	MARKETING	B	DIETARY	10		26		3
500	TOTAL RECLASSIFICATIONS				12,532	183		500
	CODE LETTER - B							
1	PHYSICIANS	C						1
2	PHYSICIANS	C	ADMINISTRATIVE & GENERAL	5		239,333		2
500	TOTAL RECLASSIFICATIONS					239,333		500
	CODE LETTER - C							
1	MISC RECLASS	D						1
2	MISC RECLASS	D	OPERATION OF PLANT	7		4,281		2
500	TOTAL RECLASSIFICATIONS					4,281		500
	CODE LETTER - D							
1	SERVICE UNDER ARRANGEMENT	E						1
2	SERVICE UNDER ARRANGEMENT	E						2
3	SERVICE UNDER ARRANGEMENT	E	RADIOLOGY-DIAGNOSTIC	54		323,903		3
4	SERVICE UNDER ARRANGEMENT	E	LABORATORY	60		364,535		4
500	TOTAL RECLASSIFICATIONS					688,438		500
	CODE LETTER - E							
1	CLINICAL PSYCHOLOGY	F						1
2	CLINICAL PSYCHOLOGY	F	ADMINISTRATIVE & GENERAL	5		43,089		2
3	CLINICAL PSYCHOLOGY	F	PSYCHOLOGY	76	34,332	517		3
500	TOTAL RECLASSIFICATIONS				34,332	43,606		500
	CODE LETTER - F							
1	CONTRACT SERVICES RECLASS	G						1
2	CONTRACT SERVICES RECLASS	G	ADMINISTRATIVE & GENERAL	5		46,674		2
500	TOTAL RECLASSIFICATIONS					46,674		500
	CODE LETTER - G							
1	PROFESSIONAL FEES	H						1
2	PROFESSIONAL FEES	H	ADMINISTRATIVE & GENERAL	5		165,000		2
500	TOTAL RECLASSIFICATIONS					165,000		500
	CODE LETTER - H							
1	BARNES JEWISH RECLASS	I						1
2	BARNES JEWISH RECLASS	I						2
3	BARNES JEWISH RECLASS	I						3
4	BARNES JEWISH RECLASS	I	EMPLOYEE BENEFITS	4		160		4
5	BARNES JEWISH RECLASS	I	ADMINISTRATIVE & GENERAL	5		122,795		5
6	BARNES JEWISH RECLASS	I	PHYSICIANS' PRIVATE OFFICES	192		42		6
500	TOTAL RECLASSIFICATIONS					122,997		500
	CODE LETTER - I							
	GRAND TOTAL (DECREASES)				46,864	1,343,261		

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	18,372,696	-26,781		-26,781		18,345,915		3
4	BUILDING IMPROVEMENTS	2,731,633	95,376		95,376		2,827,009		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	3,947,196	499,452		499,452	148,695	4,297,953		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	25,051,525	568,047		568,047	148,695	25,470,877		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	25,051,525	568,047		568,047	148,695	25,470,877		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	769,213	624,354					1,393,567	1
2	CAP REL COSTS-MVBLE EQUIP	275,001	313,820					588,821	2
3	TOTAL (SUM OF LINES 1-2)	1,044,214	938,174					1,982,388	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	21,172,924		21,172,924	0.831260		98,833		98,833	1
2	CAP REL COSTS-MVBLE EQUIP	4,297,953		4,297,953	0.168740		20,062		20,062	2
3	TOTAL (SUM OF LINES 1-2)	25,470,877		25,470,877	1.000000		118,895		118,895	3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,018,365	624,354	341,775	27,223	-411,773		1,599,944	1
2	CAP REL COSTS-MVBLE EQUIP	248,292	313,820		5,526	19,161		586,799	2
3	TOTAL	1,266,657	938,174	341,775	32,749	-392,612		2,186,743	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-19,150				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	2,577,077				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							33
34							34
35							35
36							36
37	INTEREST	A	-24,313	INTEREST EXPENSE	113	11	37
37.02	DEPRECIATION	A	61	CAP REL COSTS-MVBLE EQUIP	2	9	37.02
37.03	INSURANCE	A	-856,855	EMPLOYEE BENEFITS	4		37.03
37.04	INSURANCE	A	630,310	ADMINISTRATIVE & GENERAL	5		37.04
37.05	PROPERTY TAX	A	-4,436	CAP REL COSTS-BLDG & FIXT	1	13	37.05
37.06	PROPERTY TAX	A	-901	CAP REL COSTS-MVBLE EQUIP	2	13	37.06
37.07	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-669,097	ADMINISTRATIVE & GENERAL	5		37.07
37.08	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-24	OPERATION OF PLANT	7		37.08
37.09	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-1,509	NURSING ADMINISTRATION	13		37.09
37.10	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-110	SOCIAL SERVICE	17		37.10
37.11	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-814	ADULTS & PEDIATRICS	30		37.11
37.12	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	2	PHYSICAL THERAPY	66		37.12
37.13	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	16,667	OCCUPATIONAL THERAPY	67		37.13
37.14	NON-ALLOWABLE EXPENSES ADJUSTMENT	A	-55	MEDICAL SUPPLIES CHRGED TO PATI	71		37.14
37.15	PATIENT TELEPHONE	A	-137	CAP REL COSTS-MVBLE EQUIP	2	9	37.15
37.16	PATIENT TELEPHONE	A	-6,184	EMPLOYEE BENEFITS	4		37.16
37.17	PATIENT TELEPHONE	A	-55,902	ADMINISTRATIVE & GENERAL	5		37.17
37.18	PATIENT TELEVISION	A	-26,592	CAP REL COSTS-MVBLE EQUIP	2	9	37.18
37.19	PATIENT TELEVISION	A	-15,720	OPERATION OF PLANT	7		37.19
37.20	PRINTING	A	-25,120	ADMINISTRATIVE & GENERAL	5		37.20
37.21	PRINTING	A	1	OPERATION OF PLANT	7		37.21
37.22	PRINTING	A	65	HOUSEKEEPING	9		37.22
37.23	PRINTING	A	-30	NURSING ADMINISTRATION	13		37.23
37.25	PRINTING	A	5	PHYSICAL THERAPY	66		37.25
37.26	PRINTING	A	-22	OCCUPATIONAL THERAPY	67		37.26

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
37.27	PRINTING	A	-15	SPEECH PATHOLOGY	68		37.27
37.28	PRINTING	A	-18	MEDICAL SUPPLIES CHRGED TO PATI	71		37.28
37.29	LOBBYING EXPENSE	A	-184	EMPLOYEE BENEFITS	4		37.29
37.30	LOBBYING EXPENSE	A	-10,005	ADMINISTRATIVE & GENERAL	5		37.30
37.31	MISCELLANEOUS INCOME	B	36,557	ADMINISTRATIVE & GENERAL	5		37.31
37.32	MISCELLANEOUS INCOME	B	616	OPERATION OF PLANT	7		37.32
37.33	MISCELLANEOUS INCOME	B	56	DIETARY	10		37.33
37.34	MISCELLANEOUS INCOME	B	45	MEDICAL RECORDS & LIBRARY	16		37.34
37.35	MISCELLANEOUS INCOME	B	4,963	RADIOLOGY SUA	54.01		37.35
37.36	MISCELLANEOUS INCOME	B	7,065	RESPIRATORY THERAPY	65		37.36
37.37	MISCELLANEOUS INCOME	B	220	PHYSICAL THERAPY	66		37.37
37.38	MISCELLANEOUS INCOME	B	316	MEDICAL SUPPLIES CHRGED TO PATI	71		37.38
37.39	MISCELLANEOUS INCOME	B	501	DRUGS CHARGED TO PATIENTS	73		37.39
37.40	PATIENT TRANSPORTATION	A	-11,492	EMPLOYEE BENEFITS	4		37.40
37.41	PATIENT TRANSPORTATION	A	-124,032	OPERATION OF PLANT	7		37.41
37.42	SALE-LEASE BACK ADJUSTMENT	A	-12,300	ADMINISTRATIVE & GENERAL	5		37.42
37.43	WAYPORT WIRELESS	A	-7,110	ADMINISTRATIVE & GENERAL	5		37.43
37.44	PRINT SHOP DELIVERY	A	-1,673	ADMINISTRATIVE & GENERAL	5		37.44
37.45	CONTRACT SERVICES	A	-146,357	ADMINISTRATIVE & GENERAL	5		37.45
37.46	PHYSICIAN ADJUSTMENT	A	-80,892	ADMINISTRATIVE & GENERAL	5		37.46
37.47	PROPERTY TAX - RENT	A	-50,314	CAP REL COSTS-BLDG & FIXT	1	13	37.47
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		1,123,164				50

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	TO OFFSET MANAGEMENT FEES		1,043,077	-1,043,077		1
2	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	249,152		249,152	9	2
3	1	CAP REL COSTS-BLDG & FIXT	TO INCLUDE ALLOWABLE HOME OFFI	341,775		341,775	11	3
4	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	2,960,515		2,960,515		4
4.01	5	ADMINISTRATIVE & GENERAL	TO INCLUDE ALLOWABLE HOME OFFI	893,194		893,194		4.01
4.02	1	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY WAGE AND EXPENSE	44,857	44,857		10	4.02
4.03	2	CAP REL COSTS-MVBLE EQUIP	INTERCOMPANY WAGE AND EXPENSE	6,381	6,381		10	4.03
4.04	4	EMPLOYEE BENEFITS	INTERCOMPANY WAGE AND EXPENSE	2,263,438	2,263,438			4.04
4.05	5	ADMINISTRATIVE & GENERAL	INTERCOMPANY WAGE AND EXPENSE	1,799,978	1,799,978			4.05
4.06	7	OPERATION OF PLANT	INTERCOMPANY WAGE AND EXPENSE	19,573	19,573			4.06
4.07	8	LAUNDRY & LINEN SERVICE	INTERCOMPANY WAGE AND EXPENSE	-90	-90			4.07
4.08	9	HOUSEKEEPING	INTERCOMPANY WAGE AND EXPENSE	-171	-171			4.08
4.09	10	DIETARY	INTERCOMPANY WAGE AND EXPENSE	2,746	2,746			4.09
4.10	13	NURSING ADMINISTRATION	INTERCOMPANY WAGE AND EXPENSE	2,384	2,384			4.10
4.11	16	MEDICAL RECORDS & LIBRARY	INTERCOMPANY WAGE AND EXPENSE	893	893			4.11
4.12	30	ADULTS & PEDIATRICS	INTERCOMPANY WAGE AND EXPENSE	3,290	3,290			4.12
4.13	60	LABORATORY	INTERCOMPANY WAGE AND EXPENSE	-207	-207			4.13
4.14	65	RESPIRATORY THERAPY	INTERCOMPANY WAGE AND EXPENSE	-5	-5			4.14
4.15	66	PHYSICAL THERAPY	INTERCOMPANY WAGE AND EXPENSE	321	321			4.15
4.16	67	OCCUPATIONAL THERAPY	INTERCOMPANY WAGE AND EXPENSE	-4,580	-4,580			4.16
4.17	68	SPEECH PATHOLOGY	INTERCOMPANY WAGE AND EXPENSE	2,663	2,663			4.17
4.18	71	MEDICAL SUPPLIES CHRGED TO PATI	INTERCOMPANY WAGE AND EXPENSE	-6,071	-6,071			4.18
4.19	73	DRUGS CHARGED TO PATIENTS	INTERCOMPANY WAGE AND EXPENSE	1,134	1,134			4.19
4.20	113	INTEREST EXPENSE	INTERCOMPANY WAGE AND EXPENSE	217,226	217,226			4.20
4.21	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - MCD ADJUSTMENT	811	852	-41	9	4.21
4.22	2	CAP REL COSTS-MVBLE EQUIP	RELATED PARTY - GG ENTERPRISE	26,396	26,396		9	4.22
4.23	5	ADMINISTRATIVE & GENERAL	BARNES JEWISH	21,838	70,206	-48,368		4.23
4.24	7	OPERATION OF PLANT	BARNES JEWISH	45,966	145,794	-99,828		4.24
4.25	13	NURSING ADMINISTRATION	BARNES JEWISH	45	144	-99		4.25
4.26	54.01	RADIOLOGY SUA	BARNES JEWISH	240,786	268,123	-27,337		4.26
4.27	60.01	LAB SUA	BARNES JEWISH	272,952	272,952			4.27
4.28	113	INTEREST EXPENSE	I/C INTEREST		192,953	-192,953	11	4.28
4.29	1	CAP REL COSTS-BLDG & FIXT	RENT	117,968	573,824	-455,856	13	4.29
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		9,525,158	6,948,081	2,577,077		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			50.00	HEALTHSOUTH		HEALTHCARE	6
7			50.00	BJC HEALTHCARE		HEALTHCARE	7
8	G	HEALTHSOUTH CORP				HEALTHCARE	8
9	G	BARNES JEWISH CHRISTIAN HOSP				HEALTHCARE	9
10	G	MCD				EQUIP SUPPLIER	10
10.01	G	MOTORIKA				EQUIP SUPPLIER	10.01

(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	30	ADULTS & PEDIATRICS	AGGREGATE	239,333		239,333	171,400	2,672	220,183	11,009	1
200		TOTAL		239,333		239,333		2,672	220,183	11,009	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	30	ADULTS & PEDIATRICS	AGGREGATE					220,183	19,150	19,150	1
200		TOTAL						220,183	19,150	19,150	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,599,944	1,599,944				1
2	CAP REL COSTS-MVBLE EQUIP	586,799		586,799			2
4	EMPLOYEE BENEFITS	2,466,479			2,466,479		4
5	ADMINISTRATIVE & GENERAL	8,788,794	94,299	34,585	393,797	9,311,475	5
7	OPERATION OF PLANT	914,846	3,395	1,245	35,764	955,250	7
8	LAUNDRY & LINEN SERVICE	187,632				187,632	8
9	HOUSEKEEPING	404,061	6,578	2,412	44,665	457,716	9
10	DIETARY	1,179,887	99,781	36,596	78,441	1,394,705	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	625,231	4,385	1,608	88,921	720,145	13
16	MEDICAL RECORDS & LIBRARY	241,280	8,770	3,217	31,861	285,128	16
17	SOCIAL SERVICE	492,601	4,385	1,608	69,798	568,392	17
21	I&R SRVCES-SALARY & FRINGES APPRVD	165,000				165,000	21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	6,315,820	877,147	321,707	811,162	8,325,836	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA	301,571				301,571	54.01
60	LABORATORY						60
60.01	LAB SUA	364,695				364,695	60.01
65	RESPIRATORY THERAPY	388,754	4,385	1,608	54,234	448,981	65
66	PHYSICAL THERAPY	2,675,899	199,279	73,088	373,493	3,321,759	66
67	OCCUPATIONAL THERAPY	2,201,765	167,575	61,460	304,648	2,735,448	67
68	SPEECH PATHOLOGY	780,669	31,245	11,459	110,535	933,908	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	775,709	55,045	20,188	10,824	861,766	71
73	DRUGS CHARGED TO PATIENTS	1,408,672	11,582	4,248	51,587	1,476,089	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	32,866,108	1,567,851	575,029	2,459,730	32,815,496	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		32,040	11,751		43,791	192
194	MARKETING	12,715	53	19	1,805	14,592	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH	124,612			4,944	129,556	194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	33,003,435	1,599,944	586,799	2,466,479	33,003,435	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	9,311,475					5
7	OPERATION OF PLANT	386,298	1,341,548				7
8	LAUNDRY & LINEN SERVICE	75,877		263,509			8
9	HOUSEKEEPING	185,098	29,417		672,231		9
10	DIETARY	564,012	51,663		44,847	2,055,227	10
11	CAFETERIA					90,343	11
13	NURSING ADMINISTRATION	291,223	58,565		1,971		13
16	MEDICAL RECORDS & LIBRARY	115,304	20,985		3,942		16
17	SOCIAL SERVICE	229,855	45,970		1,971		17
21	I&R SRVCES-SALARY & FRINGES APPRVD	66,725					21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,366,926	534,239	263,509	394,233	1,448,442	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY	181,566	35,720		1,971		65
66	PHYSICAL THERAPY	1,343,303	245,991		89,566		66
67	OCCUPATIONAL THERAPY	1,106,201	200,647		75,317		67
68	SPEECH PATHOLOGY	377,668	72,801		14,043		68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	348,494	7,129		24,740		71
73	DRUGS CHARGED TO PATIENTS	596,923	33,976		5,205		73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	9,235,473	1,337,103	263,509	657,806	1,538,785	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	17,709			14,401		192
194	MARKETING	5,901	1,189		24		194
194.01	GUEST MEALS					516,442	194.01
194.02	CLINICAL PSYCH	52,392	3,256				194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,311,475	1,341,548	263,509	672,231	2,055,227	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	I+R SALARY + FRINGES	
		11	13	16	17	21	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	90,343					11
13	NURSING ADMINISTRATION	4,197	1,076,101				13
16	MEDICAL RECORDS & LIBRARY	1,504		426,863			16
17	SOCIAL SERVICE	3,295			849,483		17
21	I&R SRVCES-SALARY & FRINGES APPRVD					231,725	21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	38,295	1,076,101	167,630	849,483	231,725	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY	2,560		4,851			65
66	PHYSICAL THERAPY	17,630		90,700			66
67	OCCUPATIONAL THERAPY	14,380		77,552			67
68	SPEECH PATHOLOGY	5,218		28,552			68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	511		8,007			71
73	DRUGS CHARGED TO PATIENTS	2,435		49,571			73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	90,025	1,076,101	426,863	849,483	231,725	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES						192
194	MARKETING	85					194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH	233					194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	90,343	1,076,101	426,863	849,483	231,725	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5	ADMINISTRATIVE & GENERAL				5
7	OPERATION OF PLANT				7
8	LAUNDRY & LINEN SERVICE				8
9	HOUSEKEEPING				9
10	DIETARY				10
11	CAFETERIA				11
13	NURSING ADMINISTRATION				13
16	MEDICAL RECORDS & LIBRARY				16
17	SOCIAL SERVICE				17
21	I&R SRVCES-SALARY & FRINGES APPRVD				21
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	16,696,419		16,696,419	30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC				54
54.01	RADIOLOGY SUA	301,571		301,571	54.01
60	LABORATORY				60
60.01	LAB SUA	364,695		364,695	60.01
65	RESPIRATORY THERAPY	675,649		675,649	65
66	PHYSICAL THERAPY	5,108,949		5,108,949	66
67	OCCUPATIONAL THERAPY	4,209,545		4,209,545	67
68	SPEECH PATHOLOGY	1,432,190		1,432,190	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	1,250,647		1,250,647	71
73	DRUGS CHARGED TO PATIENTS	2,164,199		2,164,199	73
76	PSYCHOLOGY				76
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
	SPECIAL PURPOSE COST CENTERS				
113	INTEREST EXPENSE				113
118	SUBTOTALS (SUM OF LINES 1-117)	32,203,864		32,203,864	118
	NONREIMBURSABLE COST CENTERS				
192	PHYSICIANS' PRIVATE OFFICES	75,901		75,901	192
194	MARKETING	21,791		21,791	194
194.01	GUEST MEALS	516,442		516,442	194.01
194.02	CLINICAL PSYCH	185,437		185,437	194.02
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	TOTAL (SUM OF LINES 118-201)	33,003,435		33,003,435	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		94,299	34,585	128,884	128,884	5
7	OPERATION OF PLANT		3,395	1,245	4,640	5,347	7
8	LAUNDRY & LINEN SERVICE					1,050	8
9	HOUSEKEEPING		6,578	2,412	8,990	2,562	9
10	DIETARY		99,781	36,596	136,377	7,806	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION		4,385	1,608	5,993	4,031	13
16	MEDICAL RECORDS & LIBRARY		8,770	3,217	11,987	1,596	16
17	SOCIAL SERVICE		4,385	1,608	5,993	3,181	17
21	I&R SRVCES-SALARY & FRINGES APPRVD					924	21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		877,147	321,707	1,198,854	46,608	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY		4,385	1,608	5,993	2,513	65
66	PHYSICAL THERAPY		199,279	73,088	272,367	18,592	66
67	OCCUPATIONAL THERAPY		167,575	61,460	229,035	15,310	67
68	SPEECH PATHOLOGY		31,245	11,459	42,704	5,227	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		55,045	20,188	75,233	4,823	71
73	DRUGS CHARGED TO PATIENTS		11,582	4,248	15,830	8,262	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)		1,567,851	575,029	2,142,880	127,832	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES		32,040	11,751	43,791	245	192
194	MARKETING		53	19	72	82	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH					725	194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		1,599,944	586,799	2,186,743	128,884	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT	9,987					7
8	LAUNDRY & LINEN SERVICE		1,050				8
9	HOUSEKEEPING	219		11,771			9
10	DIETARY	385		785	145,353		10
11	CAFETERIA				6,389	6,389	11
13	NURSING ADMINISTRATION	436		35		297	13
16	MEDICAL RECORDS & LIBRARY	156		69		106	16
17	SOCIAL SERVICE	342		35		233	17
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,978	1,050	6,903	102,439	2,708	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY	266		35		181	65
66	PHYSICAL THERAPY	1,831		1,568		1,247	66
67	OCCUPATIONAL THERAPY	1,493		1,319		1,017	67
68	SPEECH PATHOLOGY	542		246		369	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	53		433		36	71
73	DRUGS CHARGED TO PATIENTS	253		91		172	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	9,954	1,050	11,519	108,828	6,366	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES			252			192
194	MARKETING	9				6	194
194.01	GUEST MEALS				36,525		194.01
194.02	CLINICAL PSYCH	24				17	194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,987	1,050	11,771	145,353	6,389	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION 13	MEDICAL RECORDS + LIBRARY 16	SOCIAL SERVICE 17	I+R SALARY + FRINGES 21	SUBTOTAL 24	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	10,792					13
16	MEDICAL RECORDS & LIBRARY		13,914				16
17	SOCIAL SERVICE			9,784			17
21	I&R SRVCES-SALARY & FRINGES APPRVD				924		21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,792	5,464	9,784		1,388,580	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY		158			9,146	65
66	PHYSICAL THERAPY		2,956			298,561	66
67	OCCUPATIONAL THERAPY		2,528			250,702	67
68	SPEECH PATHOLOGY		931			50,019	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		261			80,839	71
73	DRUGS CHARGED TO PATIENTS		1,616			26,224	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	10,792	13,914	9,784		2,104,071	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES					44,288	192
194	MARKETING					169	194
194.01	GUEST MEALS					36,525	194.01
194.02	CLINICAL PSYCH					766	194.02
200	CROSS FOOT ADJUSTMENTS				924	924	200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	10,792	13,914	9,784	924	2,186,743	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS			4
5	ADMINISTRATIVE & GENERAL			5
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
13	NURSING ADMINISTRATION			13
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
21	I&R SRVCES-SALARY & FRINGES APPRVD			21
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS		1,388,580	30
	ANCILLARY SERVICE COST CENTERS			
54	RADIOLOGY-DIAGNOSTIC			54
54.01	RADIOLOGY SUA			54.01
60	LABORATORY			60
60.01	LAB SUA			60.01
65	RESPIRATORY THERAPY		9,146	65
66	PHYSICAL THERAPY		298,561	66
67	OCCUPATIONAL THERAPY		250,702	67
68	SPEECH PATHOLOGY		50,019	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		80,839	71
73	DRUGS CHARGED TO PATIENTS		26,224	73
76	PSYCHOLOGY			76
	OUTPATIENT SERVICE COST CENTERS			
92	OBSERVATION BEDS			92
	OTHER REIMBURSABLE COST CENTERS			
	SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE			113
118	SUBTOTALS (SUM OF LINES 1-117)		2,104,071	118
	NONREIMBURSABLE COST CENTERS			
192	PHYSICIANS' PRIVATE OFFICES		44,288	192
194	MARKETING		169	194
194.01	GUEST MEALS		36,525	194.01
194.02	CLINICAL PSYCH		766	194.02
200	CROSS FOOT ADJUSTMENTS		924	200
201	NEGATIVE COST CENTER			201
202	TOTAL (SUM OF LINES 118-201)		2,186,743	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	90,483					1
2	CAP REL COSTS-MVBLE EQUIP		90,483				2
4	EMPLOYEE BENEFITS			17,126,400			4
5	ADMINISTRATIVE & GENERAL	5,333	5,333	2,734,400	-9,311,475	23,025,694	5
7	OPERATION OF PLANT	192	192	248,334		955,250	7
8	LAUNDRY & LINEN SERVICE					187,632	8
9	HOUSEKEEPING	372	372	310,136		457,716	9
10	DIETARY	5,643	5,643	544,672		1,394,705	10
11	CAFETERIA						11
13	NURSING ADMINISTRATION	248	248	617,436		720,145	13
16	MEDICAL RECORDS & LIBRARY	496	496	221,235		285,128	16
17	SOCIAL SERVICE	248	248	484,652		568,392	17
21	I&R SRVCES-SALARY & FRINGES APPRVD					165,000	21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	49,606	49,606	5,632,423		8,325,836	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA				-301,571		54.01
60	LABORATORY						60
60.01	LAB SUA				-364,695		60.01
65	RESPIRATORY THERAPY	248	248	376,582		448,981	65
66	PHYSICAL THERAPY	11,270	11,270	2,593,415		3,321,759	66
67	OCCUPATIONAL THERAPY	9,477	9,477	2,115,374		2,735,448	67
68	SPEECH PATHOLOGY	1,767	1,767	767,519		933,908	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	3,113	3,113	75,157		861,766	71
73	DRUGS CHARGED TO PATIENTS	655	655	358,201		1,476,089	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	88,668	88,668	17,079,536	-9,977,741	22,837,755	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES	1,812	1,812			43,791	192
194	MARKETING	3	3	12,532		14,592	194
194.01	GUEST MEALS						194.01
194.02	CLINICAL PSYCH			34,332		129,556	194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,599,944	586,799	2,466,479		9,311,475	202
203	UNIT COST MULT-WS B PT I	17.682261	6.485185	0.144016		0.404395	203
204	COST TO BE ALLOC PER B PT II					128,884	204
205	UNIT COST MULT-WS B PT II					0.005597	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		GROSS SALARIES	PATIENT DAYS	SQUARE FEET	MEALS SERVED	GROSS SALARIES	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5	ADMINISTRATIVE & GENERAL						5
7	OPERATION OF PLANT	14,143,666					7
8	LAUNDRY & LINEN SERVICE		29,174				8
9	HOUSEKEEPING	310,136		84,586			9
10	DIETARY	544,672		5,643	124,187		10
11	CAFETERIA				5,459	13,288,858	11
13	NURSING ADMINISTRATION	617,436		248		617,436	13
16	MEDICAL RECORDS & LIBRARY	221,235		496		221,235	16
17	SOCIAL SERVICE	484,652		248		484,652	17
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,632,423	29,174	49,606	87,522	5,632,423	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA						54.01
60	LABORATORY						60
60.01	LAB SUA						60.01
65	RESPIRATORY THERAPY	376,582		248		376,582	65
66	PHYSICAL THERAPY	2,593,415		11,270		2,593,415	66
67	OCCUPATIONAL THERAPY	2,115,374		9,477		2,115,374	67
68	SPEECH PATHOLOGY	767,519		1,767		767,519	68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	75,157		3,113		75,157	71
73	DRUGS CHARGED TO PATIENTS	358,201		655		358,201	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	14,096,802	29,174	82,771	92,981	13,241,994	118
	NONREIMBURSABLE COST CENTERS						
192	PHYSICIANS' PRIVATE OFFICES			1,812			192
194	MARKETING	12,532		3		12,532	194
194.01	GUEST MEALS				31,206		194.01
194.02	CLINICAL PSYCH	34,332				34,332	194.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,341,548	263,509	672,231	2,055,227	90,343	202
203	UNIT COST MULT-WS B PT I	0.094852	9.032323	7.947308	16.549454	0.006798	203
204	COST TO BE ALLOC PER B PT II	9,987	1,050	11,771	145,353	6,389	204
205	UNIT COST MULT-WS B PT II	0.000706	0.035991	0.139160	1.170437	0.000481	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINIS-TRATION PATIENT DAYS 13	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	I+R SALARY + FRINGES ASSIGNED TIME 21	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5	ADMINISTRATIVE & GENERAL					5
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
13	NURSING ADMINISTRATION	29,174				13
16	MEDICAL RECORDS & LIBRARY		59,969,617			16
17	SOCIAL SERVICE			29,174		17
21	I&R SRVCES-SALARY & FRINGES APPRVD				100	21
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	29,174	23,550,118	29,174	100	30
	ANCILLARY SERVICE COST CENTERS					
54	RADIOLOGY-DIAGNOSTIC					54
54.01	RADIOLOGY SUA					54.01
60	LABORATORY					60
60.01	LAB SUA					60.01
65	RESPIRATORY THERAPY		681,542			65
66	PHYSICAL THERAPY		12,742,345			66
67	OCCUPATIONAL THERAPY		10,895,241			67
68	SPEECH PATHOLOGY		4,011,292			68
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		1,124,949			71
73	DRUGS CHARGED TO PATIENTS		6,964,130			73
76	PSYCHOLOGY					76
	OUTPATIENT SERVICE COST CENTERS					
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	29,174	59,969,617	29,174	100	118
	NONREIMBURSABLE COST CENTERS					
192	PHYSICIANS' PRIVATE OFFICES					192
194	MARKETING					194
194.01	GUEST MEALS					194.01
194.02	CLINICAL PSYCH					194.02
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	COST TO BE ALLOC PER B PT I	1,076,101	426,863	849,483	231,725	202
203	UNIT COST MULT-WS B PT I	36.885617	0.007118	29.117810	2,317.250000	203
204	COST TO BE ALLOC PER B PT II	10,792	13,914	9,784	924	204
205	UNIT COST MULT-WS B PT II	0.369918	0.000232	0.335367	9.240000	205

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	16,696,419		16,696,419	19,150	16,715,569	30
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA	301,571		301,571		301,571	54.01
60	LABORATORY						60
60.01	LAB SUA	364,695		364,695		364,695	60.01
65	RESPIRATORY THERAPY	675,649		675,649		675,649	65
66	PHYSICAL THERAPY	5,108,949		5,108,949		5,108,949	66
67	OCCUPATIONAL THERAPY	4,209,545		4,209,545		4,209,545	67
68	SPEECH PATHOLOGY	1,432,190		1,432,190		1,432,190	68
71	MEDICAL SUPPLIES CHRGED TO	1,250,647		1,250,647		1,250,647	71
73	DRUGS CHARGED TO PATIENTS	2,164,199		2,164,199		2,164,199	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	32,203,864		32,203,864	19,150	32,223,014	200
201	LESS OBSERVATION BEDS						201
202	TOTAL (SEE INSTRUCTIONS)	32,203,864		32,203,864		32,223,014	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	23,550,118		23,550,118				30
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA	672,883	240	673,123	0.448018	0.448018	0.448018	54.01
60	LABORATORY							60
60.01	LAB SUA	896,987	934	897,921	0.406155	0.406155	0.406155	60.01
65	RESPIRATORY THERAPY	681,202	340	681,542	0.991353	0.991353	0.991353	65
66	PHYSICAL THERAPY	6,923,731	5,818,614	12,742,345	0.400943	0.400943	0.400943	66
67	OCCUPATIONAL THERAPY	7,116,098	3,779,143	10,895,241	0.386365	0.386365	0.386365	67
68	SPEECH PATHOLOGY	2,666,367	1,344,925	4,011,292	0.357040	0.357040	0.357040	68
71	MEDICAL SUPPLIES CHRGED TO	414,752	710,197	1,124,949	1.111737	1.111737	1.111737	71
73	DRUGS CHARGED TO PATIENTS	6,963,794	336	6,964,130	0.310764	0.310764	0.310764	73
76	PSYCHOLOGY							76
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	49,885,932	11,654,729	61,540,661				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	49,885,932	11,654,729	61,540,661				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	1,388,580		1,388,580	29,174	47.60	10,860	516,936	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)	1,388,580		1,388,580	29,174		10,860	516,936	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF			

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA		673,123	673,123	208,552		54.01
60	LABORATORY						60
60.01	LAB SUA		897,921	897,921	344,818		60.01
65	RESPIRATORY THERAPY	9,146	681,542	0.013420	253,597	3,403	65
66	PHYSICAL THERAPY	298,561	12,742,345	0.023431	2,584,297	60,553	66
67	OCCUPATIONAL THERAPY	250,702	10,895,241	0.023010	2,691,796	61,938	67
68	SPEECH PATHOLOGY	50,019	4,011,292	0.012470	905,784	11,295	68
71	MEDICAL SUPPLIES CHRGED TO PA	80,839	1,124,949	0.071860	134,841	9,690	71
73	DRUGS CHARGED TO PATIENTS	26,224	6,964,130	0.003766	2,559,537	9,639	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	715,491	37,990,543		9,683,222	156,518	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	29,174		10,860		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)	29,174		10,860		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
60.01	LAB SUA							60.01
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
54	RADIOLOGY-DIAGNOSTIC								54
54.01	RADIOLOGY SUA	673,123			208,552				54.01
60	LABORATORY								60
60.01	LAB SUA	897,921			344,818				60.01
65	RESPIRATORY THERAPY	681,542			253,597				65
66	PHYSICAL THERAPY	12,742,345			2,584,297		220		66
67	OCCUPATIONAL THERAPY	10,895,241			2,691,796				67
68	SPEECH PATHOLOGY	4,011,292			905,784		243		68
71	MEDICAL SUPPLIES CHRGED TO P	1,124,949			134,841		49		71
73	DRUGS CHARGED TO PATIENTS	6,964,130			2,559,537				73
76	PSYCHOLOGY								76
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	37,990,543			9,683,222		512		200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (26-3028)	[ ]	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								54
54.01	RADIOLOGY SUA	0.448018							54.01
60	LABORATORY								60
60.01	LAB SUA	0.406155							60.01
65	RESPIRATORY THERAPY	0.991353							65
66	PHYSICAL THERAPY	0.400943	220			88			66
67	OCCUPATIONAL THERAPY	0.386365							67
68	SPEECH PATHOLOGY	0.357040	243			87			68
71	MEDICAL SUPPLIES CHRGED TO PATI	1.111737	49			54			71
73	DRUGS CHARGED TO PATIENTS	0.310764							73
76	PSYCHOLOGY								76
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)		512			229			200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		512			229			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	1,388,580		1,388,580	29,174	47.60	6,191	294,692	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)	1,388,580		1,388,580	29,174		6,191	294,692	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	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) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY SUA		673,123	673,123	136,502		54.01
60	LABORATORY						60
60.01	LAB SUA		897,921	897,921	175,595		60.01
65	RESPIRATORY THERAPY	9,146	681,542	0.013420	151,762	2,037	65
66	PHYSICAL THERAPY	298,561	12,742,345	0.023431	1,412,377	33,093	66
67	OCCUPATIONAL THERAPY	250,702	10,895,241	0.023010	622,653	14,327	67
68	SPEECH PATHOLOGY	50,019	4,011,292	0.012470	1,440,596	17,964	68
71	MEDICAL SUPPLIES CHRGED TO PA	80,839	1,124,949	0.071860	85,935	6,175	71
73	DRUGS CHARGED TO PATIENTS	26,224	6,964,130	0.003766	1,494,658	5,629	73
76	PSYCHOLOGY						76
	OUTPATIENT SERVICE COST CENTERS						
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	715,491	37,990,543		5,520,078	79,225	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	29,174		6,191		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)	29,174		6,191		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY SUA							54.01
60	LABORATORY							60
60.01	LAB SUA							60.01
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHOLOGY							76
	OUTPATIENT SERVICE COST CENTERS							
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	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								54
54.01	RADIOLOGY SUA	673,123			136,502				54.01
60	LABORATORY								60
60.01	LAB SUA	897,921			175,595				60.01
65	RESPIRATORY THERAPY	681,542			151,762				65
66	PHYSICAL THERAPY	12,742,345			1,412,377				66
67	OCCUPATIONAL THERAPY	10,895,241			622,653				67
68	SPEECH PATHOLOGY	4,011,292			1,440,596				68
71	MEDICAL SUPPLIES CHRGED TO P	1,124,949			85,935				71
73	DRUGS CHARGED TO PATIENTS	6,964,130			1,494,658				73
76	PSYCHOLOGY								76
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	37,990,543			5,520,078				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (26-3028)	[ ]	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								54
54.01	RADIOLOGY SUA	0.448018							54.01
60	LABORATORY								60
60.01	LAB SUA	0.406155		6			2		60.01
65	RESPIRATORY THERAPY	0.991353		12			12		65
66	PHYSICAL THERAPY	0.400943		70,448			28,246		66
67	OCCUPATIONAL THERAPY	0.386365		56,680			21,899		67
68	SPEECH PATHOLOGY	0.357040		24,435			8,724		68
71	MEDICAL SUPPLIES CHRGED TO PATI	1.111737		8,960			9,961		71
73	DRUGS CHARGED TO PATIENTS	0.310764							73
76	PSYCHOLOGY								76
	OUTPATIENT SERVICE COST CENTERS								
92	OBSERVATION BEDS								92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			160,541			68,844		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			160,541			68,844		202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (26-3028)	[ ]	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)	29,174	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,174	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,174	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)	10,860	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	16,715,569	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	16,715,569	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	23,550,118	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	23,550,118	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.709787	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)	807.23	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	16,715,569	37

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

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (26-3028)	[ ]	SUB (OTHER)	[XX] PPS
	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
	[ ]	TITLE XIX-INPT	[ ]	IRF			[ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	572.96	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	6,222,346	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	6,222,346	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)					3,829,782	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,052,128	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					516,936	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					156,518	51
52	TOTAL PROGRAM EXCLUDABLE COST					673,454	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					9,378,674	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)	572.96	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 (26-3028)	[ ]	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)	29,174	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	29,174	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	29,174	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)	6,191	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	16,696,419	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	16,696,419	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	23,550,118	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	23,550,118	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.708974	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)	807.23	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	16,696,419	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (26-3028)	[ ]	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)	572.30 38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,543,109 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)	3,543,109 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)					2,164,151	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					5,707,260	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					294,692	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					79,225	51
52	TOTAL PROGRAM EXCLUDABLE COST					373,917	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 (26-3028)	[ ]	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		8,760,874		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC				54
54.01	RADIOLOGY SUA	0.448018	208,552	93,435	54.01
60	LABORATORY				60
60.01	LAB SUA	0.406155	344,818	140,050	60.01
65	RESPIRATORY THERAPY	0.991353	253,597	251,404	65
66	PHYSICAL THERAPY	0.400943	2,584,297	1,036,156	66
67	OCCUPATIONAL THERAPY	0.386365	2,691,796	1,040,016	67
68	SPEECH PATHOLOGY	0.357040	905,784	323,401	68
71	MEDICAL SUPPLIES CHRGED TO PATI	1.111737	134,841	149,908	71
73	DRUGS CHARGED TO PATIENTS	0.310764	2,559,537	795,412	73
76	PSYCHOLOGY				76
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		9,683,222	3,829,782	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		9,683,222		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	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		5,000,082		30
	ANCILLARY SERVICE COST CENTERS				
54	RADIOLOGY-DIAGNOSTIC				54
54.01	RADIOLOGY SUA	0.448018	136,502	61,155	54.01
60	LABORATORY				60
60.01	LAB SUA	0.406155	175,595	71,319	60.01
65	RESPIRATORY THERAPY	0.991353	151,762	150,450	65
66	PHYSICAL THERAPY	0.400943	1,412,377	566,283	66
67	OCCUPATIONAL THERAPY	0.386365	622,653	240,571	67
68	SPEECH PATHOLOGY	0.357040	1,440,596	514,350	68
71	MEDICAL SUPPLIES CHRGED TO PATI	1.111737	85,935	95,537	71
73	DRUGS CHARGED TO PATIENTS	0.310764	1,494,658	464,486	73
76	PSYCHOLOGY				76
	OUTPATIENT SERVICE COST CENTERS				
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		5,520,078	2,164,151	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		5,520,078		202

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (26-3028) [ ] 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)	229	2
3	PPS PAYMENTS	218	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)	218	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	79	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	139	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)	139	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	139	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)	139	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)	139	40
41	INTERIM PAYMENTS	139	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 (26-3028) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				15,613,239		139	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
			.02					3.02
		PROGRAM	.03					3.03
		TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				15,613,239		139	4
		TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		151,732			6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				15,764,971		139	7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III

CHECK [XX] HOSPITAL (26-3028)
APPLICABLE BOX: [ ] IRF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	NET FEDERAL PPS PAYMENT (SEE INSTRUCTIONS)	13,273,929	1
2	MEDICARE SSI RATIO (SEE INSTRUCTIONS)	0.093100	2
3	INPATIENT REHABILITATION LIP PAYMENTS (SEE INSTRUCTIONS)	2,230,644	3
4	OUTLIER PAYMENTS		4
5	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	4.37	5
5.01	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)		5.01
6	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)	5.62	7
8	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM (SEE INSTRUCTIONS)		8
9	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	4.37	9
10	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	79.710383	10
11	MEDICAL EDUCATION ADJUSTMENT FACTOR {((1 + (LINE 9/LINE 10)) RAISED TO THE POWER OF .6876 -1}	0.037381	11
12	MEDICAL EDUCATION ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 11)	496,193	12
13	TOTAL PPS PAYMENT (SUM OF LINES 1, 3, 4 AND 12)	16,000,766	13
14	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		14
15	ORGAN ACQUISITION		15
16	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		16
17	SUBTOTAL (SEE INSTRUCTIONS)	16,000,766	17
18	PRIMARY PAYER PAYMENTS	5,000	18
19	SUBTOTAL LINE 17b LESS LINE 18)	15,995,766	19
20	DEDUCTIBLES	156,248	20
21	SUBTOTAL (LINE 19 MINUS LINE 20)	15,839,518	21
22	COINSURANCE	159,999	22
23	SUBTOTAL (LINE 21 MINUS LINE 22)	15,679,519	23
24	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	122,074	24
25	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	85,452	25
26	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	122,074	26
27	SUBTOTAL (SUM OF LINES 23 AND 25)	15,764,971	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IRF ONLY)		28
29	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		29
30	OUTLIER PAYMENTS RECONCILIATION		30
31	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		31
32	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	15,764,971	32
33	INTERIM PAYMENTS	15,613,239	33
34	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		34
35	BALANCE DUE PROVIDER/PROGRAM (LINE 32 MINUS THE SUM OF LINES 33 AND 34)	151,732	35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART III, LINE 4 (SEE INSTRUCTIONS)	50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)	52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	53

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (26-3028)	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[XX]	OTHER
			[ ]	SUB (OTHER)				

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

	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	5,707,260	1
2	MEDICAL AND OTHER SERVICES	68,844	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	5,776,104	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	5,776,104	7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	5,000,082	8
9	ANCILLARY SERVICE CHARGES	5,680,619	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)	10,680,701	12
	CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	10,680,701	16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)	4,904,597	17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	5,776,104	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	5,776,104	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)	5,776,104	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)	5,776,104	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	5,776,104	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)	5,776,104	40
41	INTERIM PAYMENTS	5,908,917	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	-132,813	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,411,079				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	9,233,942				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,238,522				6
7	INVENTORY	140,437				7
8	PREPAID EXPENSES	193,208				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	9,740,144				11
	FIXED ASSETS					
12	LAND					12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	21,172,923				15
16	ACCUMULATED DEPRECIATION	-7,547,963				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	4,299,823				23
24	ACCUMULATED DEPRECIATION	-3,146,698				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)	14,778,085				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	2,718,755				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	2,718,755				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	27,236,984				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	846,654				37
38	SALARIES, WAGES & FEES PAYABLE	1,716,248				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	34,802				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,597,704				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	14,886,916				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	14,886,916				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	17,484,620				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	9,752,364				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)	9,752,364				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	27,236,984				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1 2	3 4	5 6	7 8	
1	FUND BALANCES AT BEGINNING OF PERIOD	8,794,640				1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	5,535,931				2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	14,330,571				3
4	ADDITIONS (CREDIT ADJUST-MENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	14,330,571				11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)					12
13	PARTNERSHIP DISTRIBUTION 1,810,244					13
14	MINORITY INTEREST 2,767,963					14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)	4,578,207				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	9,752,364				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	23,550,118		23,550,118	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)	23,550,118		23,550,118	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)	23,550,118		23,550,118	17
18	ANCILLARY SERVICES	26,336,391		26,336,391	18
19	OUTPATIENT SERVICES		11,654,152	11,654,152	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)	49,886,509	11,654,152	61,540,661	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		31,880,271	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		31,880,271	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	61,540,661	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	24,287,908	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	37,252,753	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	31,880,271	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	5,372,482	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	30,168	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	77	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	94,873	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	141	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	5,020	21
22	RENTAL OF HOSPITAL SPACE	38,348	22
23	GOVERNMENTAL APPROPRIATIONS		23
24		-5,178	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	163,449	25
26	TOTAL (LINE 5 PLUS LINE 25)	5,535,931	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	5,535,931	29