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: 12-02-2013 TIME: 10:16_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. MARY'S HOSPITAL (14-0026) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, 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	TITLE XVIII HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		153,365	26,358	-277,005		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		153,365	26,358	-277,005		200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 111 E. SPRING ST. P.O.BOX: 1

2 CITY: STREATOR STATE: IL ZIP CODE: 61364 COUNTY: LASALLE 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ST. MARY'S HOSPITAL	14-0026	99914	1	05/23/1966	N	P	P	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	ST. MARY'S HOME HEALTH	14-7173	99914		12/03/1979	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012	TO: 06/30/2013							20
21	TYPE OF CONTROL	1								21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	1,070	162					24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			2				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.			1				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: 07/01/2012		ENDING: 06/30/2013			38

		1	2	
39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	Y	Y	39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L,	N	N	N	46

	PART III AND L-1, PARTS I THROUGH III.				
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)

TEACHING HOSPITALS		1	2	3	
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	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.)(SEE INSTRUCTIONS)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (EXCLUDING OB/GYN AND GENERAL SURGERY) ADDED AS A RESULT OF SECTION 5503. (SEE INSTRUCTIONS)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (SEE INSTRUCTIONS)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (SEE INSTRUCTIONS)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTE AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (LINE 61.04 MINUS LINE 61.03). (SEE INSTRUCTIONS)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (SEE INSTRUCTIONS)				61.06

OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT	
1	2	3	4	
				61.10

OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (SEE INSTRUCTIONS) ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.

61.20

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

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

		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

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.	N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		76
	LONG TERM CARE HOSPITAL PPS		
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	80
	TEFRA PROVIDERS		
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	86

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

		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

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

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

	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.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 54,976 PAID LOSSES: 239,923 SELF INSURANCE: 278,696			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	Y	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y		140

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

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET: 4936 LAVERNA RD.	P.O. BOX: 19456		142
143	CITY: SPRINGFIELD	STATE: IL	ZIP CODE: 62794	143

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

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N			156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)	N	N			158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

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.	Y		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.	1.00		169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)	10/01/2011	09/30/2012	170

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

BED COMPLEMENT

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

		PART A Y/N 1	PART A DATE 2	PART B Y/N 3	PART B DATE 4	
	PS&R REPORT DATA					
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	09/18/2013	Y	09/18/2013	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)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

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

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

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: PATRICK	LAST NAME: SZAJKOVICS	TITLE: CONSULTANT	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.			42
43	PHONE NUMBER: (630) 530-7100, X-111	E-MAIL ADDRESS: PATRICK.SZAJKOVICS@SRINC.ORG		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)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	89	32,485			3,775	870	5,474	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						164			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.)		89	32,485			3,775	870	5,474	7
8	INTENSIVE CARE UNIT	31	8	2,920			586	98	1,035	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						264	424	13
14	TOTAL (SEE INSTRUCTIONS)		97	35,405			4,361	1,232	6,933	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					2,901		2,901	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		97							27
28	OBSERVATION BED DAYS							157	1,169	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								67	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								82	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
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)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					1,085	322	1,837	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						48			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)			324.80			1,085	322	1,837	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		8.38						22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			333.18						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
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
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	16,035,875		16,035,875	693,012.00	23.14	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)		724,250	-129,372	594,878	23,038.00	25.82	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		290,019		290,019	4,485.75	64.65	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		374,718		374,718	2,025.50	185.00	13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		1,482,023		1,482,023	24,842.00	59.66	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)		5,915,345		5,915,345			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		227,894		227,894			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 DEPARTMENT		214,638		214,638	8,345.83	25.72	26
27	ADMINISTRATIVE & GENERAL		2,754,398	31,679	2,786,077	120,856.01	23.05	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		89,433		89,433	828.00	108.01	28
29	MAINTENANCE & REPAIRS		449,769		449,769	17,754.55	25.33	29
30	OPERATION OF PLANT		141,213		141,213	9,449.41	14.94	30
31	LAUNDRY & LINEN SERVICE		23,131		23,131	2,584.02	8.95	31
32	HOUSEKEEPING		476,577		476,577	41,889.43	11.38	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		366,447		366,447	27,385.08	13.38	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA		25,235		25,235	2,671.33	9.45	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		973,108		973,108	31,749.28	30.65	38
39	CENTRAL SERVICES AND SUPPLY		92,900		92,900	5,384.69	17.25	39
40	PHARMACY		526,140		526,140	13,044.54	40.33	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		450,497		450,497	27,156.75	16.59	41
42	SOCIAL SERVICE			23,373	23,373	1,035.00	22.58	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	16,125,308		16,125,308	693,840.00	23.24	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	724,250	-129,372	594,878	23,038.00	25.82	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	15,401,058	129,372	15,530,430	670,802.00	23.15	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	2,146,760		2,146,760	31,353.25	68.47	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5,915,345		5,915,345		38.09%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	23,463,163	129,372	23,592,535	702,155.25	33.60	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	6,583,486	55,052	6,638,538	310,133.92	21.41	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1,533,940	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	11,753	7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	2,811,459	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	103,741	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	18,051	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	30,892	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	73,721	14
15	WORKERS' COMPENSATION INSURANCE	323,731	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	948,624	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	223,626	18
19	UNEMPLOYMENT INSURANCE	48,726	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	14,977	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	6,143,241	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA | HHA NO.: 14-7173 | WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA | COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		311			311	1
2	UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION		207.00		58.00	265.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00

		NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT) STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)	1.03		1.03	4
5	OTHER ADMINISTRATIVE PERSONNEL	2.59		2.59	5
6	DIRECT NURSING SERVICE	4.69		4.69	6
7	NURSING SUPERVISOR	1.66		1.66	7
8	PHYSICAL THERAPY SERVICE	1.32		1.32	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE	0.15		0.15	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE	0.01		0.01	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	0.42		0.42	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	0.23		0.23	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	2	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	37900	20
20.01		99914	20.01

PPS ACTIVITY

		FULL EPISODES WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
21	SKILLED NURSING VISITS	1,567		100	5	1,672	21
22	SKILLED NURSING VISIT CHARGES	313,400		20,000	1,000	334,400	22
23	PHYSICAL THERAPY VISITS	920		10	7	937	23
24	PHYSICAL THERAPY VISIT CHARGES	184,000		2,000	1,400	187,400	24
25	OCCUPATIONAL THERAPY VISITS	98		1	1	100	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	19,600		200	200	20,000	26
27	SPEECH PATHOLOGY VISITS	8				8	27
28	SPEECH PATHOLOGY VISIT CHARGES	1,600				1,600	28
29	MEDICAL SOCIAL SERVICE VISITS	95		2		97	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	25,175		530		25,705	30
31	HOME HEALTH AIDE VISITS	86		1		87	31
32	HOME HEALTH AIDE VISIT CHARGES	10,320		120		10,440	32
33	TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	2,774		114	13	2,901	33
34	OTHER CHARGES	6,171		522		6,693	34
35	TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	560,266		23,372	2,600	586,238	35
36	TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	222		44	1	267	36
37	TOTAL NUMBER OF OUTLIER EPISODES						37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	13,725		2,125		15,850	38

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.294698	1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2	NET REVENUE FROM MEDICAID	3,539,541	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	20,249,996	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	5,967,633	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	2,428,092	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	2,428,092	19

		UNINSURED PATIENTS 1	INSURED PATIENTS 2	TOTAL 3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	7,340,223	681,955	8,022,178	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	2,163,149	200,971	2,364,120	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	27,617	15,282	42,899	22
23	COST OF CHARITY CARE	2,135,532	185,689	2,321,221	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	2,413,668	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	284,873	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	2,128,795	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	627,352	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	2,948,573	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	5,376,665	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		1,624,413	1,624,413	-162,754	1
2	00200	CAP REL COSTS-MVBLE EQUIP		2,939,835	2,939,835		2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	214,638	6,633,993	6,848,631		4
5	00500	ADMINISTRATIVE & GENERAL	2,754,398	8,659,680	11,414,078	-1,157,826	5
6	00600	MAINTENANCE & REPAIRS	449,769	519,225	968,994		6
7	00700	OPERATION OF PLANT	141,213	1,079,552	1,220,765		7
8	00800	LAUNDRY & LINEN SERVICE	23,131	222,226	245,357		8
9	00900	HOUSEKEEPING	476,577	220,797	697,374		9
10	01000	DIETARY	366,447	244,128	610,575		10
11	01100	CAFETERIA	25,235	-914	24,321		11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	973,108	10,705	983,813		13
14	01400	CENTRAL SERVICES & SUPPLY	92,900	241,658	334,558	225,922	14
15	01500	PHARMACY	526,140	1,016,483	1,542,623	-969,867	15
16	01600	MEDICAL RECORDS & LIBRARY	450,497	138,616	589,113		16
17	01700	SOCIAL SERVICE				23,373	17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,849,478	113,788	1,963,266		30
31	03100	INTENSIVE CARE UNIT	690,832	28,198	719,030		31
43	04300	NURSERY	130,504	14,130	144,634		43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	1,193,911	1,785,605	2,979,516	-1,587,206	50
52	05200	DELIVERY ROOM & LABOR ROOM	130,557	29,655	160,212		52
53	05300	ANESTHESIOLOGY		114,002	114,002	1,189,505	53
54	05400	RADIOLOGY-DIAGNOSTIC	928,322	1,017,731	1,946,053		54
57	05700	CT SCAN	126,135	189,551	315,686		57
58	05800	MRI	91,541	185,471	277,012		58
60	06000	LABORATORY	998,770	1,511,330	2,510,100		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	270,917	67,265	338,182	-69,856	65
66	06600	PHYSICAL THERAPY	568,809	141,028	709,837	109,172	66
67	06700	OCCUPATIONAL THERAPY	125,385	120,188	245,573	15,323	67
68	06800	SPEECH PATHOLOGY	46,082	631	46,713		68
68.01	03040	AUDIOLOGY					68.01
69	06900	ELECTROCARDIOLOGY	23,367	43,351	66,718		69
70	07000	ELECTROENCEPHALOGRAPHY	534	128,877	129,411		70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				545,025	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				949,514	72
73	07300	DRUGS CHARGED TO PATIENTS				969,867	73
74	07400	RENAL DIALYSIS					74
76.97	07697	CARDIAC REHABILITATION	72,462	4,694	77,156		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90	09000	CLINIC	203,284	10,541	213,825		90
90.01	09001	OTTAWA CLINIC	538,728	1,419,965	1,958,693	-275,057	90.01
91	09100	EMERGENCY	827,954	1,705,577	2,533,531	-47,711	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
101	10100	HOME HEALTH AGENCY	627,579	62,460	690,039	-195,235	101
		SPECIAL PURPOSE COST CENTERS					
113	11300	INTEREST EXPENSE		154,536	154,536		113
118		SUBTOTALS (SUM OF LINES 1-117)	15,939,204	32,398,971	48,338,175	-437,811	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		34,858	34,858		190
192	19200	PHYSICIANS' PRIVATE OFFICES		1,991,825	1,991,825	437,811	192
194	07950	OTHER NONREIMBURSABLE COST	96,671	87,239	183,910		194
200		TOTAL (SUM OF LINES 118-199)	16,035,875	34,512,893	50,548,768		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	1,461,659	3,573	1,465,232	1
2	00200	CAP REL COSTS-MVBLE EQUIP	2,939,835	168,154	3,107,989	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	6,848,631	-1,107,626	5,741,005	4
5	00500	ADMINISTRATIVE & GENERAL	10,256,252	-2,756,720	7,499,532	5
6	00600	MAINTENANCE & REPAIRS	968,994		968,994	6
7	00700	OPERATION OF PLANT	1,220,765	-105	1,220,660	7
8	00800	LAUNDRY & LINEN SERVICE	245,357		245,357	8
9	00900	HOUSEKEEPING	697,374		697,374	9
10	01000	DIETARY	610,575	-18,562	592,013	10
11	01100	CAFETERIA	24,321		24,321	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	983,813	-800	983,013	13
14	01400	CENTRAL SERVICES & SUPPLY	560,480		560,480	14
15	01500	PHARMACY	572,756	-2,206	570,550	15
16	01600	MEDICAL RECORDS & LIBRARY	589,113	-22,333	566,780	16
17	01700	SOCIAL SERVICE	23,373		23,373	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,963,266	-275	1,962,991	30
31	03100	INTENSIVE CARE UNIT	719,030		719,030	31
43	04300	NURSERY	144,634	-477	144,157	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,392,310		1,392,310	50
52	05200	DELIVERY ROOM & LABOR ROOM	160,212		160,212	52
53	05300	ANESTHESIOLOGY	1,303,507	-1,189,505	114,002	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,946,053	-1,522	1,944,531	54
57	05700	CT SCAN	315,686		315,686	57
58	05800	MRI	277,012		277,012	58
60	06000	LABORATORY	2,510,100	-25,069	2,485,031	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	268,326		268,326	65
66	06600	PHYSICAL THERAPY	819,009		819,009	66
67	06700	OCCUPATIONAL THERAPY	260,896		260,896	67
68	06800	SPEECH PATHOLOGY	46,713		46,713	68
68.01	03040	AUDIOLOGY				68.01
69	06900	ELECTROCARDIOLOGY	66,718	-36,378	30,340	69
70	07000	ELECTROENCEPHALOGRAPHY	129,411	-2,200	127,211	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	545,025	-1,741	543,284	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	949,514		949,514	72
73	07300	DRUGS CHARGED TO PATIENTS	969,867		969,867	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION	77,156		77,156	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90	09000	CLINIC	213,825		213,825	90
90.01	09001	OTTAWA CLINIC	1,683,636	-922,952	760,684	90.01
91	09100	EMERGENCY	2,485,820	-1,638,165	847,655	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
101	10100	HOME HEALTH AGENCY	494,804		494,804	101
		SPECIAL PURPOSE COST CENTERS				
113	11300	INTEREST EXPENSE	154,536	-154,536		113
118		SUBTOTALS (SUM OF LINES 1-117)	47,900,364	-7,709,445	40,190,919	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,858		34,858	190
192	19200	PHYSICIANS' PRIVATE OFFICES	2,429,636	-1,601,617	828,019	192
194	07950	OTHER NONREIMBURSABLE COST	183,910		183,910	194
200		TOTAL (SUM OF LINES 118-199)	50,548,768	-9,311,062	41,237,706	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	SUPPLIES CHARGED PATIENTS	A	CENTRAL SERVICES & SUPPLY	14		225,922	1
500	TOTAL RECLASSIFICATIONS					225,922	500
	CODE LETTER - A						
1	DRUGS CHARGED TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		969,867	1
500	TOTAL RECLASSIFICATIONS					969,867	500
	CODE LETTER - B						
1	MEDICAL AND SURGICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		47,711	1
2			MEDICAL SUPPLIES CHARGED TO P	71		637,692	2
3			MEDICAL SUPPLIES CHARGED TO P	71		69,856	3
4			MEDICAL SUPPLIES CHARGED TO P	71		5,686	4
5			MEDICAL SUPPLIES CHARGED TO P	71		2,116	5
6			IMPL. DEV. CHARGED TO PATIENT	72		949,514	6
500	TOTAL RECLASSIFICATIONS					1,712,575	500
	CODE LETTER - C						
1	HHA MEDICAL SUPPLIES	D	MEDICAL SUPPLIES CHARGED TO P	71		7,886	1
500	TOTAL RECLASSIFICATIONS					7,886	500
	CODE LETTER - D						
1	HOME HEALTH BILLER COST	E	ADMINISTRATIVE & GENERAL	5	31,679		1
500	TOTAL RECLASSIFICATIONS				31,679		500
	CODE LETTER - E						
1	HHA SPECIALISTS SALARY	F	SOCIAL SERVICE	17	23,373		1
2			PHYSICAL THERAPY	66	114,858		2
3			OCCUPATIONAL THERAPY	67	17,439		3
500	TOTAL RECLASSIFICATIONS				155,670		500
	CODE LETTER - F						
1	PHYSICIAN EXPENSES	G	PHYSICIANS' PRIVATE OFFICES	192		374,718	1
500	TOTAL RECLASSIFICATIONS					374,718	500
	CODE LETTER - G						
1	CLINIC DEPRECIATION EXP	H	OTTAWA CLINIC	90.01		77,946	1
2			PHYSICIANS' PRIVATE OFFICES	192		2,370	2
500	TOTAL RECLASSIFICATIONS					80,316	500
	CODE LETTER - H						
1	PHYSICIAN UTILITIES EXP	I	PHYSICIANS' PRIVATE OFFICES	192		624	1
500	TOTAL RECLASSIFICATIONS					624	500
	CODE LETTER - I						
1	PHYSICIAN STAFF EXPENSE	J	PHYSICIANS' PRIVATE OFFICES	192	57,977		1
500	TOTAL RECLASSIFICATIONS				57,977		500
	CODE LETTER - J						
1	ANESTHESIA PHYSICIAN COST	K	ANESTHESIOLOGY	53		1,189,505	1
500	TOTAL RECLASSIFICATIONS					1,189,505	500
	CODE LETTER - K						
1	PHYSICIANS BLDGS DEPR	L	PHYSICIANS' PRIVATE OFFICES	192		2,122	1
500	TOTAL RECLASSIFICATIONS					2,122	500
	CODE LETTER - L						
1	OTTAWA CLINIC BLDG DEPR	M	OTTAWA CLINIC	90.01		80,316	1
500	TOTAL RECLASSIFICATIONS					80,316	500
	CODE LETTER - M						
	GRAND TOTAL (INCREASES)				245,326	4,643,851	

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	SUPPLIES CHARGED PATIENTS	A	MEDICAL SUPPLIES CHARGED TO P	71		225,922	1
500	TOTAL RECLASSIFICATIONS					225,922	500
	CODE LETTER - A						
1	DRUGS CHARGED TO PATIENTS	B	PHARMACY	15		969,867	1
500	TOTAL RECLASSIFICATIONS					969,867	500
	CODE LETTER - B						
1	MEDICAL AND SURGICAL SUPPLIES	C	EMERGENCY	91		47,711	1
2			OPERATING ROOM	50		637,692	2
3			RESPIRATORY THERAPY	65		69,856	3
4			PHYSICAL THERAPY	66		5,686	4
5			OCCUPATIONAL THERAPY	67		2,116	5
6			OPERATING ROOM	50		949,514	6
500	TOTAL RECLASSIFICATIONS					1,712,575	500
	CODE LETTER - C						
1	HHA MEDICAL SUPPLIES	D	HOME HEALTH AGENCY	101		7,886	1
500	TOTAL RECLASSIFICATIONS					7,886	500
	CODE LETTER - D						
1	HOME HEALTH BILLER COST	E	HOME HEALTH AGENCY	101	31,679		1
500	TOTAL RECLASSIFICATIONS				31,679		500
	CODE LETTER - E						
1	HHA SPECIALISTS SALARY	F	HOME HEALTH AGENCY	101	23,373		1
2			HOME HEALTH AGENCY	101	114,858		2
3			HOME HEALTH AGENCY	101	17,439		3
500	TOTAL RECLASSIFICATIONS				155,670		500
	CODE LETTER - F						
1	PHYSICIAN EXPENSES	G	OTTAWA CLINIC	90.01		374,718	1
500	TOTAL RECLASSIFICATIONS					374,718	500
	CODE LETTER - G						
1	CLINIC DEPRECIATION EXP	H	CAP REL COSTS-BLDG & FIXT	1		80,316	9 1
2							9 2
500	TOTAL RECLASSIFICATIONS					80,316	500
	CODE LETTER - H						
1	PHYSICIAN UTILITIES EXP	I	OTTAWA CLINIC	90.01		624	1
500	TOTAL RECLASSIFICATIONS					624	500
	CODE LETTER - I						
1	PHYSICIAN STAFF EXPENSE	J	OTTAWA CLINIC	90.01	57,977		1
500	TOTAL RECLASSIFICATIONS				57,977		500
	CODE LETTER - J						
1	ANESTHESIA PHYSICIAN COST	K	ADMINISTRATIVE & GENERAL	5		1,189,505	1
500	TOTAL RECLASSIFICATIONS					1,189,505	500
	CODE LETTER - K						
1	PHYSICIANS BLDGS DEPR	L	CAP REL COSTS-BLDG & FIXT	1		2,122	9 1
500	TOTAL RECLASSIFICATIONS					2,122	500
	CODE LETTER - L						
1	OTTAWA CLINIC BLDG DEPR	M	CAP REL COSTS-BLDG & FIXT	1		80,316	9 1
500	TOTAL RECLASSIFICATIONS					80,316	500
	CODE LETTER - M						
	GRAND TOTAL (DECREASES)				245,326	4,643,851	

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	1,234,827	25,097		25,097		1,259,924		1
2	LAND IMPROVEMENTS	979,977				3,167	976,810		2
3	BUILDINGS AND FIXTURES	51,627,392				49,633	51,577,759		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	25,685,221	609,775		609,775		26,294,996		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	79,527,417	634,872		634,872	52,800	80,109,489		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	79,527,417	634,872		634,872	52,800	80,109,489		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	1,624,413						1,624,413	1
2	CAP REL COSTS-MVBLE EQUIP	2,939,835						2,939,835	2
3	TOTAL (SUM OF LINES 1-2)	4,564,248						4,564,248	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITALIZED LEASES 2	COMPUTATION OF RATIOS GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	COMPUTATION OF RATIOS RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	ALLOCATION OF OTHER CAPITAL TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT									1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (SUM OF LINES 1-2)									3

	DESCRIPTION	SUMMARY OF CAPITAL 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	1,465,232						1,465,232	1
2	CAP REL COSTS-MVBLE EQUIP	3,107,989						3,107,989	2
3	TOTAL	4,573,221						4,573,221	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)	B	-2,641	ADMINISTRATIVE & GENERAL	5	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	-3,793,508			10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-1,334,043			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	B	-22,333	MEDICAL RECORDS & LIBRARY	16	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	DEPT INC/GUARD MEALS	B	-14,562	DIETARY	10	33
33.01	X-RAY DEPT INC	B	-202	RADIOLOGY-DIAGNOSTIC	54	33.01
33.02	OTHER REVENUE	B	-275	ADULTS & PEDIATRICS	30	33.02
33.03	DIETARY INCOME	B	-4,000	DIETARY	10	33.03
33.04	OTHER INCOME	B	-800	NURSING ADMINISTRATION	13	33.04
33.05	OTHER INCOME	B	-1,741	MEDICAL SUPPLIES CHARGED TO PAT	71	33.05
33.06	OTHER INCOME	B	-105	OPERATION OF PLANT	7	33.06
33.07	OTHER INCOME	B	-2,803	ADMINISTRATIVE & GENERAL	5	33.07
33.08	NON ALLOWABLE ADVERTISING	A	-22,021	OTTAWA CLINIC	90.01	33.08
33.09	OTHER INCOME	B	-43,408	ADMINISTRATIVE & GENERAL	5	33.09
33.10	ASSOC DUE LOBBY	B	-21,502	ADMINISTRATIVE & GENERAL	5	33.10
33.11	EDUCATION	B	-5,366	ADMINISTRATIVE & GENERAL	5	33.11
34	OTHER INCOME	B	-10,435	ADMINISTRATIVE & GENERAL	5	34
35	INTEREST	B	-154,536	INTEREST EXPENSE	113	35
36	HSHS SELF IND EXP	B	-1,107,626	EMPLOYEE BENEFITS DEPARTMENT	4	36
37	OTHER INCOME	B	-25,710	ADMINISTRATIVE & GENERAL	5	37
38	A&G NON ALLOWABLE	A	-1,130,135	ADMINISTRATIVE & GENERAL	5	38
39	OTHER INCOME	B	-2,206	PHARMACY	15	39
40	OTHER INCOME	B	-8,950	ADMINISTRATIVE & GENERAL	5	40
41	OTHER INCOME	B	-477	NURSERY	43	41
42	OTHER INCOME	B	-60	LABORATORY	60	42
43	MEDICAL GROUP ASSESSMENT	B	-1,601,617	PHYSICIANS' PRIVATE OFFICES	192	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)		-9,311,062			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	CENTRAL MANAGEMENT SERVIC	823,458	3,446,656	-2,623,198		1
2	5	ADMINISTRATIVE & GENERAL	CENTRAL MANAGEMENT SERVIC	1,751,488	634,060	1,117,428		2
3	1	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	16,785	13,212	3,573	9	3
3.01	2	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	789,920	621,766	168,154	9	4.01
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		3,381,651	4,715,694	-1,334,043		5

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS		
1	2	3	4	5	6		
6	B HOSPITAL SISTERS	100.00					6
7							7
8							8
9							9
10							10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9	
1	69	ELECTROCARDIOLOGY	AGGREGATE	36,378	36,378		159,800				1
2	91	EMERGENCY	AGGREGATE	1,638,165	1,638,165		159,800				2
3	60	LABORATORY	AGGREGATE	25,009	25,009		208,000				3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE	1,320	1,320		217,600				4
5	53	ANESTHESIOLOGY	AGGREGATE	1,189,505	1,189,505		162,500				5
6	90.01	OTTAWA CLINIC	AGGREGATE	1,056,582	681,864	374,718	159,800	2,026	155,651	7,783	6
7	70	ELECTROENCEPHALOGRAPHY	AGGREGATE	2,200	2,200		159,800				7
200		TOTAL		3,949,159	3,574,441	374,718		2,026	155,651	7,783	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	69	ELECTROCARDIOLOGY	AGGREGATE							36,378	1
2	91	EMERGENCY	AGGREGATE							1,638,165	2
3	60	LABORATORY	AGGREGATE							25,009	3
4	54	RADIOLOGY-DIAGNOSTIC	AGGREGATE							1,320	4
5	53	ANESTHESIOLOGY	AGGREGATE							1,189,505	5
6	90.01	OTTAWA CLINIC	AGGREGATE					155,651	219,067	900,931	6
7	70	ELECTROENCEPHALOGRAPHY	AGGREGATE							2,200	7
200		TOTAL						155,651	219,067	3,793,508	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 DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	1,465,232	1,465,232				1
2	CAP REL COSTS-MVBLE EQUIP	3,107,989		3,107,989			2
4	EMPLOYEE BENEFITS DEPARTMENT	5,741,005	6,126	387	5,747,518		4
5	ADMINISTRATIVE & GENERAL	7,499,532	376,346	502,331	1,012,116	9,390,325	5
6	MAINTENANCE & REPAIRS	968,994	35,544	19,126	163,392	1,187,056	6
7	OPERATION OF PLANT	1,220,660	311,238	9,623	51,300	1,592,821	7
8	LAUNDRY & LINEN SERVICE	245,357	12,671	214	8,403	266,645	8
9	HOUSEKEEPING	697,374	17,430	1,313	173,130	889,247	9
10	DIETARY	592,013	46,517	22,614	133,122	794,266	10
11	CAFETERIA	24,321	11,475	577	9,167	45,540	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	983,013	9,911		353,510	1,346,434	13
14	CENTRAL SERVICES & SUPPLY	560,480	19,792	94,119	33,749	708,140	14
15	PHARMACY	570,550	15,193	113,566	191,136	890,445	15
16	MEDICAL RECORDS & LIBRARY	566,780	19,781	2,535	163,656	752,752	16
17	SOCIAL SERVICE	23,373			8,491	31,864	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,962,991	145,796	97,738	671,877	2,878,402	30
31	INTENSIVE CARE UNIT	719,030	26,554	29,436	250,965	1,025,985	31
43	NURSERY	144,157	18,808	18,919	47,409	229,293	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,392,310	88,254	448,288	433,723	2,362,575	50
52	DELIVERY ROOM & LABOR ROOM	160,212	23,230	38,657	47,429	269,528	52
53	ANESTHESIOLOGY	114,002	2,672	18,793		135,467	53
54	RADIOLOGY-DIAGNOSTIC	1,944,531	75,438	847,798	337,240	3,205,007	54
57	CT SCAN	315,686	6,649	64,695	45,822	432,852	57
58	MRI	277,012	7,742	362,033	33,255	680,042	58
60	LABORATORY	2,485,031	41,012	80,730	362,832	2,969,605	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	268,326	8,135	18,867	98,418	393,746	65
66	PHYSICAL THERAPY	819,009	25,638	12,310	248,362	1,105,319	66
67	OCCUPATIONAL THERAPY	260,896	21,096	1,942	51,885	335,819	67
68	SPEECH PATHOLOGY	46,713	3,625	41	16,741	67,120	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	30,340	2,211	30,309	8,489	71,349	69
70	ELECTROENCEPHALOGRAPHY	127,211	580	739	194	128,724	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	543,284				543,284	71
72	IMPL. DEV. CHARGED TO PATIENTS	949,514				949,514	72
73	DRUGS CHARGED TO PATIENTS	969,867				969,867	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	77,156	13,676	3,806	26,324	120,962	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	213,825	8,399	2,559	73,849	298,632	90
90.01	OTTAWA CLINIC	760,684		98,265	174,647	1,033,596	90.01
91	EMERGENCY	847,655	40,981	36,850	300,778	1,226,264	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	494,804	19,212	10,149	159,926	684,091	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	40,190,919	1,461,732	2,989,329	5,691,337	40,012,578	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,858	1,947			36,805	190
192	PHYSICIANS' PRIVATE OFFICES	828,019		74,976	21,062	924,057	192
194	OTHER NONREIMBURSABLE COST	183,910	1,553	43,684	35,119	264,266	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	41,237,706	1,465,232	3,107,989	5,747,518	41,237,706	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE + REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL	9,390,325					5
6	MAINTENANCE & REPAIRS	350,008	1,537,064				6
7	OPERATION OF PLANT	469,650	545,391	2,607,862			7
8	LAUNDRY & LINEN SERVICE	78,621	3,782	44,900	393,948		8
9	HOUSEKEEPING	262,198	21,562	61,762		1,234,769	9
10	DIETARY	234,193	42,793	164,827	1,313	337	10
11	CAFETERIA	13,428	11,047	40,661		19,352	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	397,001	17,058	35,120		2,825	13
14	CENTRAL SERVICES & SUPPLY	208,798	120,860	70,129	3,514	15,642	14
15	PHARMACY	262,551	9,255	53,835	619	9,318	15
16	MEDICAL RECORDS & LIBRARY	221,952	4,545	70,092		4,638	16
17	SOCIAL SERVICE	9,395					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	848,708	90,890	516,610	157,921	362,203	30
31	INTENSIVE CARE UNIT	302,516	60,497	94,093	36,143	50,087	31
43	NURSERY	67,608	2,024	66,643		6,113	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	696,615	192,457	312,719	60,680	90,773	50
52	DELIVERY ROOM & LABOR ROOM	79,471	52,756	82,313		11,721	52
53	ANESTHESIOLOGY	39,943	111	9,468		2,108	53
54	RADIOLOGY-DIAGNOSTIC	945,005	55,200	267,306	29,559	48,865	54
57	CT SCAN	127,628	3,129	23,560	5,641	10,119	57
58	MRI	200,513	14,320	27,431	909		58
60	LABORATORY	875,600	45,768	145,323	47	47,389	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	116,098	20,032	28,826		1,476	65
66	PHYSICAL THERAPY	325,908	16,399	90,845	11,982	12,353	66
67	OCCUPATIONAL THERAPY	99,018	2,344	74,753	5,513	11,594	67
68	SPEECH PATHOLOGY	19,791	553	12,844			68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	21,038	3,362	7,835	1,878		69
70	ELECTROENCEPHALOGRAPHY	37,955	4,047	2,055	1,016	1,982	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	160,189					71
72	IMPL. DEV. CHARGED TO PATIENTS	279,968					72
73	DRUGS CHARGED TO PATIENTS	285,969					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	35,666	20,014	48,459	1,656	16,907	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	88,053	8,523	29,762	11,929	23,821	90
90.01	OTTAWA CLINIC	304,760	29,148		5,473	75,890	90.01
91	EMERGENCY	361,569	53,973	145,213	57,529	188,797	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	201,707	16,686	68,074		11,383	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	9,029,091	1,468,526	2,595,458	393,322	1,025,693	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,852	1,216	6,899		295	190
192	PHYSICIANS' PRIVATE OFFICES	272,462	66,260		626	201,614	192
194	OTHER NONREIMBURSABLE COST	77,920	1,062	5,505		7,167	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,390,325	1,537,064	2,607,862	393,948	1,234,769	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	1,237,729					10
11	CAFETERIA		130,028				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		9,070	1,807,508			13
14	CENTRAL SERVICES & SUPPLY		1,552	37,717	1,166,352		14
15	PHARMACY		3,759	91,391	1,850	1,323,023	15
16	MEDICAL RECORDS & LIBRARY		7,758		11		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,045,805	22,736	552,698	67,619		30
31	INTENSIVE CARE UNIT	163,280	6,922	168,275	17,329		31
43	NURSERY		1,313	31,914	2,075		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	13,509	12,651	307,537	590,942		50
52	DELIVERY ROOM & LABOR ROOM		1,313	31,914	3,657		52
53	ANESTHESIOLOGY				68,945		53
54	RADIOLOGY-DIAGNOSTIC		10,443		91,224		54
57	CT SCAN		1,193		2	908	57
58	MRI		895		212		58
60	LABORATORY		12,591		4,921	219	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		3,103	75,434	245	53	65
66	PHYSICAL THERAPY		5,371		270		66
67	OCCUPATIONAL THERAPY		1,372		84		67
68	SPEECH PATHOLOGY		239				68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY		358	8,704	92		69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				255,244		71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS					1,321,668	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		835	20,309	1,538		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,981	1,790	43,519	10,029		90
90.01	OTTAWA CLINIC		6,087		5,758	157	90.01
91	EMERGENCY	13,154	10,144	246,610	35,786		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		6,266	152,318	7,210		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	1,237,729	127,761	1,768,340	1,165,043	1,323,005	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				7		190
192	PHYSICIANS' PRIVATE OFFICES		656		1,045	18	192
194	OTHER NONREIMBURSABLE COST		1,611	39,168	257		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,237,729	130,028	1,807,508	1,166,352	1,323,023	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	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 DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,061,748					16
17	SOCIAL SERVICE		41,259				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	552,110		7,095,702		7,095,702	30
31	INTENSIVE CARE UNIT	53,087		1,978,214		1,978,214	31
43	NURSERY	10,617		417,600		417,600	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	138,027		4,778,485		4,778,485	50
52	DELIVERY ROOM & LABOR ROOM			532,673		532,673	52
53	ANESTHESIOLOGY			256,042		256,042	53
54	RADIOLOGY-DIAGNOSTIC			4,652,609		4,652,609	54
57	CT SCAN			605,032		605,032	57
58	MRI			924,322		924,322	58
60	LABORATORY			4,101,463		4,101,463	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			639,013		639,013	65
66	PHYSICAL THERAPY			1,568,447		1,568,447	66
67	OCCUPATIONAL THERAPY			530,497		530,497	67
68	SPEECH PATHOLOGY			100,547		100,547	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY			114,616		114,616	69
70	ELECTROENCEPHALOGRAPHY			175,779		175,779	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			958,717		958,717	71
72	IMPL. DEV. CHARGED TO PATIENTS			1,229,482		1,229,482	72
73	DRUGS CHARGED TO PATIENTS			2,577,504		2,577,504	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION			266,346		266,346	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC			518,039		518,039	90
90.01	OTTAWA CLINIC			1,460,869		1,460,869	90.01
91	EMERGENCY	307,907		2,646,946		2,646,946	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		41,259	1,188,994		1,188,994	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	1,061,748	41,259	39,317,938		39,317,938	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			56,074		56,074	190
192	PHYSICIANS' PRIVATE OFFICES			1,466,738		1,466,738	192
194	OTHER NONREIMBURSABLE COST			396,956		396,956	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,061,748	41,259	41,237,706		41,237,706	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		6,126	387	6,513	6,513	4
5	ADMINISTRATIVE & GENERAL	634,506	376,346	502,331	1,513,183	1,141	5
6	MAINTENANCE & REPAIRS		35,544	19,126	54,670	185	6
7	OPERATION OF PLANT		311,238	9,623	320,861	58	7
8	LAUNDRY & LINEN SERVICE		12,671	214	12,885	10	8
9	HOUSEKEEPING		17,430	1,313	18,743	196	9
10	DIETARY		46,517	22,614	69,131	151	10
11	CAFETERIA		11,475	577	12,052	10	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		9,911		9,911	401	13
14	CENTRAL SERVICES & SUPPLY		19,792	94,119	113,911	38	14
15	PHARMACY		15,193	113,566	128,759	217	15
16	MEDICAL RECORDS & LIBRARY		19,781	2,535	22,316	186	16
17	SOCIAL SERVICE					10	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		145,796	97,738	243,534	762	30
31	INTENSIVE CARE UNIT		26,554	29,436	55,990	285	31
43	NURSERY		18,808	18,919	37,727	54	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		88,254	448,288	536,542	492	50
52	DELIVERY ROOM & LABOR ROOM		23,230	38,657	61,887	54	52
53	ANESTHESIOLOGY		2,672	18,793	21,465		53
54	RADIOLOGY-DIAGNOSTIC		75,438	847,798	923,236	382	54
57	CT SCAN		6,649	64,695	71,344	52	57
58	MRI		7,742	362,033	369,775	38	58
60	LABORATORY		41,012	80,730	121,742	411	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		8,135	18,867	27,002	112	65
66	PHYSICAL THERAPY		25,638	12,310	37,948	282	66
67	OCCUPATIONAL THERAPY		21,096	1,942	23,038	59	67
68	SPEECH PATHOLOGY		3,625	41	3,666	19	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY		2,211	30,309	32,520	10	69
70	ELECTROENCEPHALOGRAPHY		580	739	1,319		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		13,676	3,806	17,482	30	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		8,399	2,559	10,958	84	90
90.01	OTTAWA CLINIC			98,265	98,265	198	90.01
91	EMERGENCY		40,981	36,850	77,831	341	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		19,212	10,149	29,361	181	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	634,506	1,461,732	2,989,329	5,085,567	6,449	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,947		1,947		190
192	PHYSICIANS' PRIVATE OFFICES			74,976	74,976	24	192
194	OTHER NONREIMBURSABLE COST		1,553	43,684	45,237	40	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	634,506	1,465,232	3,107,989	5,207,727	6,513	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE + REPAIRS 6	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL	1,514,324					5
6	MAINTENANCE & REPAIRS	56,443	111,298				6
7	OPERATION OF PLANT	75,737	39,491	436,147			7
8	LAUNDRY & LINEN SERVICE	12,679	274	7,509	33,357		8
9	HOUSEKEEPING	42,283	1,561	10,329		73,112	9
10	DIETARY	37,767	3,099	27,566	111	20	10
11	CAFETERIA	2,165	800	6,800		1,146	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	64,022	1,235	5,874		167	13
14	CENTRAL SERVICES & SUPPLY	33,671	8,751	11,729	298	926	14
15	PHARMACY	42,340	670	9,004	52	552	15
16	MEDICAL RECORDS & LIBRARY	35,793	329	11,722		275	16
17	SOCIAL SERVICE	1,515					17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	136,865	6,581	86,401	13,372	21,447	30
31	INTENSIVE CARE UNIT	48,785	4,381	15,736	3,060	2,966	31
43	NURSERY	10,903	147	11,146		362	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	112,338	13,936	52,300	5,138	5,375	50
52	DELIVERY ROOM & LABOR ROOM	12,816	3,820	13,766		694	52
53	ANESTHESIOLOGY	6,441	8	1,583		125	53
54	RADIOLOGY-DIAGNOSTIC	152,405	3,997	44,705	2,503	2,893	54
57	CT SCAN	20,582	227	3,940	478	599	57
58	MRI	32,335	1,037	4,588	77		58
60	LABORATORY	141,202	3,314	24,304	4	2,806	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	18,722	1,451	4,821		87	65
66	PHYSICAL THERAPY	52,557	1,187	15,193	1,015	731	66
67	OCCUPATIONAL THERAPY	15,968	170	12,502	467	687	67
68	SPEECH PATHOLOGY	3,191	40	2,148			68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	3,393	243	1,310	159		69
70	ELECTROENCEPHALOGRAPHY	6,121	293	344	86	117	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,833					71
72	IMPL. DEV. CHARGED TO PATIENTS	45,148					72
73	DRUGS CHARGED TO PATIENTS	46,116					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	5,752	1,449	8,104	140	1,001	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	14,200	617	4,977	1,010	1,410	90
90.01	OTTAWA CLINIC	49,146	2,111		463	4,494	90.01
91	EMERGENCY	58,308	3,908	24,286	4,871	11,179	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	32,528	1,208	11,385		674	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	1,456,070	106,335	434,072	33,304	60,733	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,750	88	1,154		17	190
192	PHYSICIANS' PRIVATE OFFICES	43,938	4,798		53	11,938	192
194	OTHER NONREIMBURSABLE COST	12,566	77	921		424	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,514,324	111,298	436,147	33,357	73,112	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	137,845					10
11	CAFETERIA		22,973				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		1,603	83,213			13
14	CENTRAL SERVICES & SUPPLY		274	1,736	171,334		14
15	PHARMACY		664	4,207	272	186,737	15
16	MEDICAL RECORDS & LIBRARY		1,371		2		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	116,470	4,017	25,446	9,932		30
31	INTENSIVE CARE UNIT	18,184	1,223	7,747	2,545		31
43	NURSERY		232	1,469	305		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,505	2,235	14,158	86,818		50
52	DELIVERY ROOM & LABOR ROOM		232	1,469	537		52
53	ANESTHESIOLOGY				10,126		53
54	RADIOLOGY-DIAGNOSTIC		1,845		13,399		54
57	CT SCAN		211			128	57
58	MRI		158		31		58
60	LABORATORY		2,225		723	31	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		548	3,473	36	7	65
66	PHYSICAL THERAPY		949		40		66
67	OCCUPATIONAL THERAPY		242		12		67
68	SPEECH PATHOLOGY		42				68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY		63	401	14		69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				37,490		71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS					186,546	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		148	935	226		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	221	316	2,004	1,473		90
90.01	OTTAWA CLINIC		1,075		846	22	90.01
91	EMERGENCY	1,465	1,792	11,353	5,256		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		1,107	7,012	1,059		101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	137,845	22,572	81,410	171,142	186,734	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				1		190
192	PHYSICIANS' PRIVATE OFFICES		116		153	3	192
194	OTHER NONREIMBURSABLE COST		285	1,803	38		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	137,845	22,973	83,213	171,334	186,737	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	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 DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	71,994					16
17	SOCIAL SERVICE		1,525				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	37,437		702,264		702,264	30
31	INTENSIVE CARE UNIT	3,600		164,502		164,502	31
43	NURSERY	720		63,065		63,065	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,359		840,196		840,196	50
52	DELIVERY ROOM & LABOR ROOM			95,275		95,275	52
53	ANESTHESIOLOGY			39,748		39,748	53
54	RADIOLOGY-DIAGNOSTIC			1,145,365		1,145,365	54
57	CT SCAN			97,561		97,561	57
58	MRI			408,039		408,039	58
60	LABORATORY			296,762		296,762	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			56,259		56,259	65
66	PHYSICAL THERAPY			109,902		109,902	66
67	OCCUPATIONAL THERAPY			53,145		53,145	67
68	SPEECH PATHOLOGY			9,106		9,106	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY			38,113		38,113	69
70	ELECTROENCEPHALOGRAPHY			8,280		8,280	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			63,323		63,323	71
72	IMPL. DEV. CHARGED TO PATIENTS			45,148		45,148	72
73	DRUGS CHARGED TO PATIENTS			232,662		232,662	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION			35,267		35,267	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC			37,270		37,270	90
90.01	OTTAWA CLINIC			156,620		156,620	90.01
91	EMERGENCY	20,878		221,468		221,468	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		1,525	86,040		86,040	101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	71,994	1,525	5,005,380		5,005,380	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			4,957		4,957	190
192	PHYSICIANS' PRIVATE OFFICES			135,999		135,999	192
194	OTHER NONREIMBURSABLE COST			61,391		61,391	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	71,994	1,525	5,207,727		5,207,727	202

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	282,955					1
2	CAP REL COSTS-MVBLE EQUIP		2,247,052				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,183	280	15,821,237			4
5	ADMINISTRATIVE & GENERAL	72,677	363,181	2,786,077	-9,390,325	31,847,381	5
6	MAINTENANCE & REPAIRS	6,864	13,828	449,769		1,187,056	6
7	OPERATION OF PLANT	60,104	6,957	141,213		1,592,821	7
8	LAUNDRY & LINEN SERVICE	2,447	155	23,131		266,645	8
9	HOUSEKEEPING	3,366	949	476,577		889,247	9
10	DIETARY	8,983	16,350	366,447		794,266	10
11	CAFETERIA	2,216	417	25,235		45,540	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,914		973,108		1,346,434	13
14	CENTRAL SERVICES & SUPPLY	3,822	68,047	92,900		708,140	14
15	PHARMACY	2,934	82,107	526,140		890,445	15
16	MEDICAL RECORDS & LIBRARY	3,820	1,833	450,497		752,752	16
17	SOCIAL SERVICE			23,373		31,864	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	28,155	70,664	1,849,478		2,878,402	30
31	INTENSIVE CARE UNIT	5,128	21,282	690,832		1,025,985	31
43	NURSERY	3,632	13,678	130,504		229,293	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	17,043	324,109	1,193,911		2,362,575	50
52	DELIVERY ROOM & LABOR ROOM	4,486	27,949	130,557		269,528	52
53	ANESTHESIOLOGY	516	13,587			135,467	53
54	RADIOLOGY-DIAGNOSTIC	14,568	612,952	928,322		3,205,007	54
57	CT SCAN	1,284	46,774	126,135		432,852	57
58	MRI	1,495	261,747	91,541		680,042	58
60	LABORATORY	7,920	58,367	998,770		2,969,605	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,571	13,641	270,917		393,746	65
66	PHYSICAL THERAPY	4,951	8,900	683,667		1,105,319	66
67	OCCUPATIONAL THERAPY	4,074	1,404	142,824		335,819	67
68	SPEECH PATHOLOGY	700	30	46,082		67,120	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	427	21,913	23,367		71,349	69
70	ELECTROENCEPHALOGRAPHY	112	534	534		128,724	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					543,284	71
72	IMPL. DEV. CHARGED TO PATIENTS					949,514	72
73	DRUGS CHARGED TO PATIENTS					969,867	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	2,641	2,752	72,462		120,962	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,622	1,850	203,284		298,632	90
90.01	OTTAWA CLINIC		71,045	480,751		1,033,596	90.01
91	EMERGENCY	7,914	26,642	827,954		1,226,264	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	3,710	7,338	440,230		684,091	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	282,279	2,161,262	15,666,589	-9,390,325	30,622,253	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	376				36,805	190
192	PHYSICIANS' PRIVATE OFFICES		54,207	57,977		924,057	192
194	OTHER NONREIMBURSABLE COST	300	31,583	96,671		264,266	194

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,465,232	3,107,989	5,747,518		9,390,325	202
203	UNIT COST MULT-WS B PT I	5.178322	1.383141	0.363279		0.294854	203
204	COST TO BE ALLOC PER B PT II			6,513		1,514,324	204
205	UNIT COST MULT-WS B PT II			0.000412		0.047549	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE + REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS	695,021					6
7	OPERATION OF PLANT	246,613	142,127				7
8	LAUNDRY & LINEN SERVICE	1,710	2,447	58,521			8
9	HOUSEKEEPING	9,750	3,366		29,287		9
10	DIETARY	19,350	8,983	195	8	24,371	10
11	CAFETERIA	4,995	2,216		459		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	7,713	1,914		67		13
14	CENTRAL SERVICES & SUPPLY	54,650	3,822	522	371		14
15	PHARMACY	4,185	2,934	92	221		15
16	MEDICAL RECORDS & LIBRARY	2,055	3,820		110		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	41,098	28,155	23,459	8,591	20,592	30
31	INTENSIVE CARE UNIT	27,355	5,128	5,369	1,188	3,215	31
43	NURSERY	915	3,632		145		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	87,024	17,043	9,014	2,153	266	50
52	DELIVERY ROOM & LABOR ROOM	23,855	4,486		278		52
53	ANESTHESIOLOGY	50	516		50		53
54	RADIOLOGY-DIAGNOSTIC	24,960	14,568	4,391	1,159		54
57	CT SCAN	1,415	1,284	838	240		57
58	MRI	6,475	1,495	135			58
60	LABORATORY	20,695	7,920	7	1,124		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	9,058	1,571		35		65
66	PHYSICAL THERAPY	7,415	4,951	1,780	293		66
67	OCCUPATIONAL THERAPY	1,060	4,074	819	275		67
68	SPEECH PATHOLOGY	250	700				68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	1,520	427	279			69
70	ELECTROENCEPHALOGRAPHY	1,830	112	151	47		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	9,050	2,641	246	401		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,854	1,622	1,772	565	39	90
90.01	OTTAWA CLINIC	13,180		813	1,800		90.01
91	EMERGENCY	24,405	7,914	8,546	4,478	259	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	7,545	3,710		270		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	664,030	141,451	58,428	24,328	24,371	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	550	376		7		190
192	PHYSICIANS' PRIVATE OFFICES	29,961		93	4,782		192
194	OTHER NONREIMBURSABLE COST	480	300		170		194

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE + REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,537,064	2,607,862	393,948	1,234,769	1,237,729	202
203	UNIT COST MULT-WS B PT I	2.211536	18.348815	6.731737	42.160993	50.786960	203
204	COST TO BE ALLOC PER B PT II	111,298	436,147	33,357	73,112	137,845	204
205	UNIT COST MULT-WS B PT II	0.160136	3.068713	0.570001	2.496398	5.656108	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA MEALS SERVED 11	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	2,179					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	152	1,246				13
14	CENTRAL SERVICES & SUPPLY	26	26	105,882,026			14
15	PHARMACY	63	63	167,950	97,086,056		15
16	MEDICAL RECORDS & LIBRARY	130		1,002		1,000	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	381	381	6,138,218		520	30
31	INTENSIVE CARE UNIT	116	116	1,573,114		50	31
43	NURSERY	22	22	188,354		10	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	212	212	53,648,111		130	50
52	DELIVERY ROOM & LABOR ROOM	22	22	331,992			52
53	ANESTHESIOLOGY			6,258,582			53
54	RADIOLOGY-DIAGNOSTIC	175		8,281,073			54
57	CT SCAN	20		166	66,640		57
58	MRI	15		19,277			58
60	LABORATORY	211		446,715	16,040		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	52	52	22,232	3,888		65
66	PHYSICAL THERAPY	90		24,503			66
67	OCCUPATIONAL THERAPY	23		7,631			67
68	SPEECH PATHOLOGY	4					68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	6	6	8,357			69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			23,170,316			71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS				96,986,656		73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	14	14	139,570			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	30	30	910,402			90
90.01	OTTAWA CLINIC	102		522,660	11,509		90.01
91	EMERGENCY	170	170	3,248,525		290	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	105	105	654,507			101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,141	1,219	105,763,257	97,084,733	1,000	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			600			190
192	PHYSICIANS' PRIVATE OFFICES	11		94,853	1,323		192
194	OTHER NONREIMBURSABLE COST	27	27	23,316			194

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA MEALS SERVED 11	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	130,028	1,807,508	1,166,352	1,323,023	1,061,748	202
203	UNIT COST MULT-WS B PT I	59.673245	1,450.648475	0.011016	0.013627	1,061.748000	203
204	COST TO BE ALLOC PER B PT II	22,973	83,213	171,334	186,737	71,994	204
205	UNIT COST MULT-WS B PT II	10.542910	66.784109	0.001618	0.001923	71.994000	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE TIME SPENT 17	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE	1,038	17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES APPRVD		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS		30
31	INTENSIVE CARE UNIT		31
43	NURSERY		43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM		50
52	DELIVERY ROOM & LABOR ROOM		52
53	ANESTHESIOLOGY		53
54	RADIOLOGY-DIAGNOSTIC		54
57	CT SCAN		57
58	MRI		58
60	LABORATORY		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY		65
66	PHYSICAL THERAPY		66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
68.01	AUDIOLOGY		68.01
69	ELECTROCARDIOLOGY		69
70	ELECTROENCEPHALOGRAPHY		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		71
72	IMPL. DEV. CHARGED TO PATIENTS		72
73	DRUGS CHARGED TO PATIENTS		73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90	CLINIC		90
90.01	OTTAWA CLINIC		90.01
91	EMERGENCY		91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
	OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS		94
101	HOME HEALTH AGENCY	1,038	101
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	1,038	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192	PHYSICIANS' PRIVATE OFFICES		192
194	OTHER NONREIMBURSABLE COST		194

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	41,259	202
203	UNIT COST MULT-WS B PT I	39.748555	203
204	COST TO BE ALLOC PER B PT II	1,525	204
205	UNIT COST MULT-WS B PT II	1.469171	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	7,095,702		7,095,702		7,095,702	30
31	INTENSIVE CARE UNIT	1,978,214		1,978,214		1,978,214	31
43	NURSERY	417,600		417,600		417,600	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,778,485		4,778,485		4,778,485	50
52	DELIVERY ROOM & LABOR ROOM	532,673		532,673		532,673	52
53	ANESTHESIOLOGY	256,042		256,042		256,042	53
54	RADIOLOGY-DIAGNOSTIC	4,652,609		4,652,609		4,652,609	54
57	CT SCAN	605,032		605,032		605,032	57
58	MRI	924,322		924,322		924,322	58
60	LABORATORY	4,101,463		4,101,463		4,101,463	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	639,013		639,013		639,013	65
66	PHYSICAL THERAPY	1,568,447		1,568,447		1,568,447	66
67	OCCUPATIONAL THERAPY	530,497		530,497		530,497	67
68	SPEECH PATHOLOGY	100,547		100,547		100,547	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	114,616		114,616		114,616	69
70	ELECTROENCEPHALOGRAPHY	175,779		175,779		175,779	70
71	MEDICAL SUPPLIES CHARGED TO	958,717		958,717		958,717	71
72	IMPL. DEV. CHARGED TO PATIE	1,229,482		1,229,482		1,229,482	72
73	DRUGS CHARGED TO PATIENTS	2,577,504		2,577,504		2,577,504	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	266,346		266,346		266,346	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	518,039		518,039		518,039	90
90.01	OTTAWA CLINIC	1,460,869		1,460,869	219,067	1,679,936	90.01
91	EMERGENCY	2,646,946		2,646,946		2,646,946	91
92	OBSERVATION BEDS (NON-DISTI	1,248,667		1,248,667		1,248,667	92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	1,188,994		1,188,994		1,188,994	101
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	40,566,605		40,566,605	219,067	40,785,672	200
201	LESS OBSERVATION BEDS	1,248,667		1,248,667		1,248,667	201
202	TOTAL (SEE INSTRUCTIONS)	39,317,938		39,317,938		39,537,005	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	6,386,120		6,386,120				30
31	INTENSIVE CARE UNIT	2,539,363		2,539,363				31
43	NURSERY	470,963		470,963				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,185,125	12,256,712	16,441,837	0.290630	0.290630	0.290630	50
52	DELIVERY ROOM & LABOR ROOM	229,481	178,865	408,346	1.304465	1.304465	1.304465	52
53	ANESTHESIOLOGY	1,336,775	2,613,419	3,950,194	0.064818	0.064818	0.064818	53
54	RADIOLOGY-DIAGNOSTIC	2,502,978	17,198,512	19,701,490	0.236155	0.236155	0.236155	54
57	CT SCAN	1,804,735	11,073,245	12,877,980	0.046982	0.046982	0.046982	57
58	MRI	58,165	3,726,676	3,784,841	0.244217	0.244217	0.244217	58
60	LABORATORY	4,842,379	16,188,293	21,030,672	0.195023	0.195023	0.195023	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	1,572,368	304,771	1,877,139	0.340419	0.340419	0.340419	65
66	PHYSICAL THERAPY	496,306	2,518,403	3,014,709	0.520265	0.520265	0.520265	66
67	OCCUPATIONAL THERAPY	121,316	1,412,835	1,534,151	0.345792	0.345792	0.345792	67
68	SPEECH PATHOLOGY	46,095	148,860	194,955	0.515745	0.515745	0.515745	68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY	438,715	1,206,000	1,644,715	0.069687	0.069687	0.069687	69
70	ELECTROENCEPHALOGRAPHY		586,872	586,872	0.299518	0.299518	0.299518	70
71	MEDICAL SUPPLIES CHARGED TO	2,466,805	3,045,202	5,512,007	0.173932	0.173932	0.173932	71
72	IMPL. DEV. CHARGED TO PATIE	2,444,297	823,313	3,267,610	0.376263	0.376263	0.376263	72
73	DRUGS CHARGED TO PATIENTS	5,333,057	3,764,200	9,097,257	0.283328	0.283328	0.283328	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	188	904,949	905,137	0.294260	0.294260	0.294260	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	338,110	2,829,286	3,167,396	0.163554	0.163554	0.163554	90
90.01	OTTAWA CLINIC		1,943,170	1,943,170	0.751797	0.751797	0.864534	90.01
91	EMERGENCY	1,659,370	7,846,859	9,506,229	0.278443	0.278443	0.278443	91
92	OBSERVATION BEDS (NON-DISTI	184,951	2,497,142	2,682,093	0.465557	0.465557	0.465557	92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
101	HOME HEALTH AGENCY		892,563	892,563				101
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	39,457,662	93,960,147	133,417,809				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	39,457,662	93,960,147	133,417,809				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	702,264		702,264	6,643	105.71	3,775	399,055	30
31	INTENSIVE CARE UNIT	164,502		164,502	1,035	158.94	586	93,139	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	63,065		63,065	424	148.74			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	929,831		929,831	8,102		4,361	492,194	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES [ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX [XX] HOSPITAL (14-0026) [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	840,196	16,441,837	0.051101	2,507,018	128,111	50
52	DELIVERY ROOM & LABOR ROOM	95,275	408,346	0.233319	11	3	52
53	ANESTHESIOLOGY	39,748	3,950,194	0.010062	677,658	6,819	53
54	RADIOLOGY-DIAGNOSTIC	1,145,365	19,701,490	0.058136	1,915,415	111,355	54
57	CT SCAN	97,561	12,877,980	0.007576	1,456,514	11,035	57
58	MRI	408,039	3,784,841	0.107809	33,620	3,625	58
60	LABORATORY	296,762	21,030,672	0.014111	3,646,097	51,450	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	56,259	1,877,139	0.029971	1,325,474	39,726	65
66	PHYSICAL THERAPY	109,902	3,014,709	0.036455	399,823	14,576	66
67	OCCUPATIONAL THERAPY	53,145	1,534,151	0.034641	91,941	3,185	67
68	SPEECH PATHOLOGY	9,106	194,955	0.046708	40,406	1,887	68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	38,113	1,644,715	0.023173	360,080	8,344	69
70	ELECTROENCEPHALOGRAPHY	8,280	586,872	0.014109			70
71	MEDICAL SUPPLIES CHARGED TO P	63,323	5,512,007	0.011488	1,692,174	19,440	71
72	IMPL. DEV. CHARGED TO PATIENT	45,148	3,267,610	0.013817	1,558,088	21,528	72
73	DRUGS CHARGED TO PATIENTS	232,662	9,097,257	0.025575	4,059,765	103,828	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	35,267	905,137	0.038963			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	37,270	3,167,396	0.011767	11,331	133	90
90.01	OTTAWA CLINIC	156,620	1,943,170	0.080600			90.01
91	EMERGENCY	221,468	9,506,229	0.023297	1,543,398	35,957	91
92	OBSERVATION BEDS (NON-DISTINC	123,581	2,682,093	0.046076	184,951	8,522	92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	4,113,090	123,128,800		21,503,764	569,524	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	6,643		3,775		30
31	INTENSIVE CARE UNIT	1,035		586		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	424				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	8,102		4,361		200

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

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	OTTAWA CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES
[ ] TITLE V [XX] HOSPITAL (14-0026) [ ] 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	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	16,441,837			2,507,018		2,767,810	50
52	DELIVERY ROOM & LABOR ROOM	408,346			11			52
53	ANESTHESIOLOGY	3,950,194			677,658		507,909	53
54	RADIOLOGY-DIAGNOSTIC	19,701,490			1,915,415		3,117,588	54
57	CT SCAN	12,877,980			1,456,514		2,160,072	57
58	MRI	3,784,841			33,620		637,073	58
60	LABORATORY	21,030,672			3,646,097		591,358	60
62.30	BLOOD CLOTTING FOR HEMOPHILI							62.30
65	RESPIRATORY THERAPY	1,877,139			1,325,474		49,298	65
66	PHYSICAL THERAPY	3,014,709			399,823		122	66
67	OCCUPATIONAL THERAPY	1,534,151			91,941			67
68	SPEECH PATHOLOGY	194,955			40,406			68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY	1,644,715			360,080		270,590	69
70	ELECTROENCEPHALOGRAPHY	586,872					88,786	70
71	MEDICAL SUPPLIES CHARGED TO	5,512,007			1,692,174		669,863	71
72	IMPL. DEV. CHARGED TO PATIEN	3,267,610			1,558,088		233,897	72
73	DRUGS CHARGED TO PATIENTS	9,097,257			4,059,765		972,305	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	905,137					305,775	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	3,167,396			11,331			90
90.01	OTTAWA CLINIC	1,943,170						90.01
91	EMERGENCY	9,506,229			1,543,398		855,385	91
92	OBSERVATION BEDS (NON-DISTIN	2,682,093			184,951		327,345	92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)	123,128,800			21,503,764		13,555,176	200

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

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	O/P PGM CHARGES 12.01	O/P PGM CHARGES 12.02	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12.01) 13.01	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12.02) 13.02	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,767,810					50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY	507,909					53
54	RADIOLOGY-DIAGNOSTIC	3,117,588					54
57	CT SCAN	2,160,072					57
58	MRI	637,073					58
60	LABORATORY	591,358					60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	49,298					65
66	PHYSICAL THERAPY	122					66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	270,590					69
70	ELECTROENCEPHALOGRAPHY	88,786					70
71	MEDICAL SUPPLIES CHARGED TO	669,863					71
72	IMPL. DEV. CHARGED TO PATIEN	233,897					72
73	DRUGS CHARGED TO PATIENTS	972,305					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	305,775					76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OTTAWA CLINIC						90.01
91	EMERGENCY	855,385					91
92	OBSERVATION BEDS (NON-DISTIN	327,345					92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	13,555,176					200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0026)	[ ]	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	PPS REIMBURSED SERVICES	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	
		1	2	2.01	2.02	3	4	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.290630	2,767,810	2,767,810		2,490		50
52	DELIVERY ROOM & LABOR ROOM	1.304465						52
53	ANESTHESIOLOGY	0.064818	507,909	507,909		391		53
54	RADIOLOGY-DIAGNOSTIC	0.236155	3,117,588	3,117,588				54
57	CT SCAN	0.046982	2,160,072	2,160,072		935		57
58	MRI	0.244217	637,073	637,073				58
60	LABORATORY	0.195023	591,358	591,358				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.340419	49,298	49,298				65
66	PHYSICAL THERAPY	0.520265	122	122				66
67	OCCUPATIONAL THERAPY	0.345792						67
68	SPEECH PATHOLOGY	0.515745						68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY	0.069687	270,590	270,590				69
70	ELECTROENCEPHALOGRAPHY	0.299518	88,786	88,786				70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.173932	669,863	669,863		38,836		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.376263	233,897	233,897				72
73	DRUGS CHARGED TO PATIENTS	0.283328	972,305	972,305		1,037	20,324	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	0.294260	305,775	305,775				76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	0.163554						90
90.01	OTTAWA CLINIC	0.751797						90.01
91	EMERGENCY	0.278443	855,385	855,385				91
92	OBSERVATION BEDS (NON-DISTINCT	0.465557	327,345	327,345				92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	SUBTOTAL (SEE INSTRUCTIONS)		13,555,176	13,555,176		43,689	20,324	200
201	LESS PBP CLINIC LAB SERVICES							201
202	NET CHARGES (LINE 200 - LINE 201)		13,555,176	13,555,176		43,689	20,324	202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0026)	[ ]	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	PROGRAM COST PPS SERVICES 5	PPS SERVICES 5.01	PPS SERVICES 5.02	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	804,409	804,409		724		50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY	32,922	32,922		25		53
54	RADIOLOGY-DIAGNOSTIC	736,234	736,234				54
57	CT SCAN	101,485	101,485		44		57
58	MRI	155,584	155,584				58
60	LABORATORY	115,328	115,328				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	16,782	16,782				65
66	PHYSICAL THERAPY	63	63				66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	18,857	18,857				69
70	ELECTROENCEPHALOGRAPHY	26,593	26,593				70
71	MEDICAL SUPPLIES CHARGED TO PAT	116,511	116,511		6,755		71
72	IMPL. DEV. CHARGED TO PATIENTS	88,007	88,007				72
73	DRUGS CHARGED TO PATIENTS	275,481	275,481		294	5,758	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	89,977	89,977				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OTTAWA CLINIC						90.01
91	EMERGENCY	238,176	238,176				91
92	OBSERVATION BEDS (NON-DISTINCT	152,398	152,398				92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	SUBTOTAL (SEE INSTRUCTIONS)	2,968,807	2,968,807		7,842	5,758	200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)	2,968,807	2,968,807		7,842	5,758	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	702,264		702,264	6,643	105.71	870	91,968	30
31	INTENSIVE CARE UNIT	164,502		164,502	1,035	158.94	98	15,576	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	63,065		63,065	424	148.74	264	39,267	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	929,831		929,831	8,102		1,232	146,811	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[XX] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[ ] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	840,196	16,441,837	0.051101			50
52	DELIVERY ROOM & LABOR ROOM	95,275	408,346	0.233319			52
53	ANESTHESIOLOGY	39,748	3,950,194	0.010062			53
54	RADIOLOGY-DIAGNOSTIC	1,145,365	19,701,490	0.058136			54
57	CT SCAN	97,561	12,877,980	0.007576			57
58	MRI	408,039	3,784,841	0.107809			58
60	LABORATORY	296,762	21,030,672	0.014111			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	56,259	1,877,139	0.029971			65
66	PHYSICAL THERAPY	109,902	3,014,709	0.036455			66
67	OCCUPATIONAL THERAPY	53,145	1,534,151	0.034641			67
68	SPEECH PATHOLOGY	9,106	194,955	0.046708			68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY	38,113	1,644,715	0.023173			69
70	ELECTROENCEPHALOGRAPHY	8,280	586,872	0.014109			70
71	MEDICAL SUPPLIES CHARGED TO P	63,323	5,512,007	0.011488			71
72	IMPL. DEV. CHARGED TO PATIENT	45,148	3,267,610	0.013817			72
73	DRUGS CHARGED TO PATIENTS	232,662	9,097,257	0.025575			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	35,267	905,137	0.038963			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	37,270	3,167,396	0.011767			90
90.01	OTTAWA CLINIC	156,620	1,943,170	0.080600			90.01
91	EMERGENCY	221,468	9,506,229	0.023297			91
92	OBSERVATION BEDS (NON-DISTINC	123,581	2,682,093	0.046076			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	4,113,090	123,128,800				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	6,643		870		30
31	INTENSIVE CARE UNIT	1,035		98		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	424		264		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	8,102		1,232		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	OTTAWA CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	16,441,837							50
52	DELIVERY ROOM & LABOR ROOM	408,346							52
53	ANESTHESIOLOGY	3,950,194							53
54	RADIOLOGY-DIAGNOSTIC	19,701,490							54
57	CT SCAN	12,877,980							57
58	MRI	3,784,841							58
60	LABORATORY	21,030,672							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	1,877,139							65
66	PHYSICAL THERAPY	3,014,709							66
67	OCCUPATIONAL THERAPY	1,534,151							67
68	SPEECH PATHOLOGY	194,955							68
68.01	AUDIOLOGY								68.01
69	ELECTROCARDIOLOGY	1,644,715							69
70	ELECTROENCEPHALOGRAPHY	586,872							70
71	MEDICAL SUPPLIES CHARGED TO	5,512,007							71
72	IMPL. DEV. CHARGED TO PATIEN	3,267,610							72
73	DRUGS CHARGED TO PATIENTS	9,097,257							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	905,137							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,167,396							90
90.01	OTTAWA CLINIC	1,943,170							90.01
91	EMERGENCY	9,506,229							91
92	OBSERVATION BEDS (NON-DISTIN	2,682,093							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	123,128,800							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0026)	[ ]	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	PPS REIMBURSED SERVICES	PPS REIMBURSED SERVICES	COST REIMB. SERVICES SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	
		1	2	2.01	2.02	3	4	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.290630						50
52	DELIVERY ROOM & LABOR ROOM	1.304465						52
53	ANESTHESIOLOGY	0.064818						53
54	RADIOLOGY-DIAGNOSTIC	0.236155						54
57	CT SCAN	0.046982						57
58	MRI	0.244217						58
60	LABORATORY	0.195023						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.340419						65
66	PHYSICAL THERAPY	0.520265						66
67	OCCUPATIONAL THERAPY	0.345792						67
68	SPEECH PATHOLOGY	0.515745						68
68.01	AUDIOLOGY							68.01
69	ELECTROCARDIOLOGY	0.069687						69
70	ELECTROENCEPHALOGRAPHY	0.299518						70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.173932						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.376263						72
73	DRUGS CHARGED TO PATIENTS	0.283328						73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	0.294260						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	0.163554						90
90.01	OTTAWA CLINIC	0.751797						90.01
91	EMERGENCY	0.278443						91
92	OBSERVATION BEDS (NON-DISTINCT	0.465557						92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	SUBTOTAL (SEE INSTRUCTIONS)							200
201	LESS PBP CLINIC LAB SERVICES							201
202	NET CHARGES (LINE 200 - LINE 201)							202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0026)	[ ]	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	PROGRAM COST PPS SERVICES 5	PPS SERVICES 5.01	PPS SERVICES 5.02	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PAT						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OTTAWA CLINIC						90.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	SUBTOTAL (SEE INSTRUCTIONS)						200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)						202

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0026)	[ ]	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)	6,643	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,643	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,474	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,775	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)	7,095,702	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	7,095,702	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	7,095,702	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ] TITLE V-INPT	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ] TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,068.15	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	4,032,266	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)	4,032,266	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	1,978,214	1,035	1,911.32	586	1,120,034	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					5,298,082	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					10,450,382	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	492,194	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	569,524	51
52	TOTAL PROGRAM EXCLUDABLE COST	1,061,718	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	9,388,664	53

	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63

	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)	1,169	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,068.15	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	1,248,667	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	702,264	7,095,702	0.098970	1,248,667	123,581	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST — PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	6,643	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,643	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,474	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)	870	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)	424	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	264	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)	7,095,702	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	7,095,702	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		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)		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)	7,095,702	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ] TITLE V-INPT	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[XX]	PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[XX] TITLE XIX-INPT	[ ]	IRF			[ ]	OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,068.15	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	929,291	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)	929,291	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)	417,600	424	984.91	264	260,016	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	1,978,214	1,035	1,911.32	98	187,309	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,376,616	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					146,811	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST					146,811	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					1,229,805	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)	1,169	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	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		4,729,897		30
31	INTENSIVE CARE UNIT		1,201,361		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.290630	2,507,018	728,615	50
52	DELIVERY ROOM & LABOR ROOM	1.304465	11	14	52
53	ANESTHESIOLOGY	0.064818	677,658	43,924	53
54	RADIOLOGY-DIAGNOSTIC	0.236155	1,915,415	452,335	54
57	CT SCAN	0.046982	1,456,514	68,430	57
58	MRI	0.244217	33,620	8,211	58
60	LABORATORY	0.195023	3,646,097	711,073	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.340419	1,325,474	451,217	65
66	PHYSICAL THERAPY	0.520265	399,823	208,014	66
67	OCCUPATIONAL THERAPY	0.345792	91,941	31,792	67
68	SPEECH PATHOLOGY	0.515745	40,406	20,839	68
68.01	AUDIOLOGY				68.01
69	ELECTROCARDIOLOGY	0.069687	360,080	25,093	69
70	ELECTROENCEPHALOGRAPHY	0.299518			70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.173932	1,692,174	294,323	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.376263	1,558,088	586,251	72
73	DRUGS CHARGED TO PATIENTS	0.283328	4,059,765	1,150,245	73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	0.294260			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.163554	11,331	1,853	90
90.01	OTTAWA CLINIC	0.864534			90.01
91	EMERGENCY	0.278443	1,543,398	429,748	91
92	OBSERVATION BEDS (NON-DISTINCT	0.465557	184,951	86,105	92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		21,503,764	5,298,082	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		21,503,764		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[ ]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.290630			50
52	DELIVERY ROOM & LABOR ROOM	1.304465			52
53	ANESTHESIOLOGY	0.064818			53
54	RADIOLOGY-DIAGNOSTIC	0.236155			54
57	CT SCAN	0.046982			57
58	MRI	0.244217			58
60	LABORATORY	0.195023			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.340419			65
66	PHYSICAL THERAPY	0.520265			66
67	OCCUPATIONAL THERAPY	0.345792			67
68	SPEECH PATHOLOGY	0.515745			68
68.01	AUDIOLOGY				68.01
69	ELECTROCARDIOLOGY	0.069687			69
70	ELECTROENCEPHALOGRAPHY	0.299518			70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.173932			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.376263			72
73	DRUGS CHARGED TO PATIENTS	0.283328			73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	0.294260			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.163554			90
90.01	OTTAWA CLINIC	0.864534			90.01
91	EMERGENCY	0.278443			91
92	OBSERVATION BEDS (NON-DISTINCT	0.465557			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A

CHECK [XX] HOSPITAL (14-0026)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,016,922	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	131,826	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	285,690	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	93.80	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.0333	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.1740	31
32	SUM OF LINES 30 AND 31	0.2073	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.0631	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	442,768	34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	7,591,516	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)	9,651,904	48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	9,136,807	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	572,304	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A

CHECK [XX] HOSPITAL (14-0026)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	9,709,111	59
60	PRIMARY PAYER PAYMENTS	3,748	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	9,705,363	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	870,452	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	7,323	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	229,783	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	160,848	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	169,641	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	8,988,436	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
70.93	HVBP PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	-51,413	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-1,971	70.94
70.96	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2012)		70.96
70.97	LOW VOLUME ADJUSTMENT FOR FISCAL YEAR (2013)	233,662	70.97
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	9,168,714	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	45,844	71.01
72	INTERIM PAYMENTS	8,969,505	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	153,365	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	105,956	75

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0026) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	13,600		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	2,968,807	2,968,807	2
3	PPS PAYMENTS	2,113,651	2,149,143	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.840	0.840	5
6	LINE 2 TIMES LINE 5	2,493,798	2,493,798	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0.8476	0.8618	7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	323,125		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)	13,600		11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES	64,013		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)	64,013		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)	64,013		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	50,413		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)	13,600		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	4,585,919		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,034,198		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	3,565,321		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)	3,565,321		30
31	PRIMARY PAYER PAYMENTS	208		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	3,565,113		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)	177,178		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	124,025		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	131,351		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	3,689,138		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			39
40	SUBTOTAL (SEE INSTRUCTIONS)	3,689,138		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	18,446		40.01
41	INTERIM PAYMENTS	3,644,334		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	26,358		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			44
	TO BE COMPLETED BY CONTRACTOR			
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)			91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY			92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)			93
94	TOTAL (SUM OF LINES 91 AND 93)			94

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

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-0026) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				8,987,427		3,618,995	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	02/06/2013	25,339	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	02/06/2013	17,922		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		-17,922		25,339	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)				8,969,505		3,644,334	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		199,209		44,804	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				9,168,714		3,689,138	7

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

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

CHECK APPLICABLE BOX [XX] HOSPITAL (14-0026) [ ] CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,837	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	4,361	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	164	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	6,509	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	133,417,809	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	8,022,178	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,580,969	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,857,974	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-277,005	32

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0026)	[ ]	SNF	[XX]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[ ]	OTHER
			[ ]	SUB (OTHER)				

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

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

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	-506,381				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	43,777,273				4
5	OTHER RECEIVABLES	457,521				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-36,436,027				6
7	INVENTORY	921,883				7
8	PREPAID EXPENSES	350,634				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	8,564,903				11
	FIXED ASSETS					
12	LAND	1,259,921				12
13	LAND IMPROVEMENTS	976,810				13
14	ACCUMULATED DEPRECIATION	-752,786				14
15	BUILDINGS	43,085,254				15
16	ACCUMULATED DEPRECIATION	-16,223,267				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	8,797,189				19
20	ACCUMULATED DEPRECIATION	-5,706,427				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	26,294,997				23
24	ACCUMULATED DEPRECIATION	-20,113,466				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)	37,618,225				30
	OTHER ASSETS					
31	INVESTMENTS	30,715,923				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	3,996,954				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	34,712,877				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	80,896,005				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,066,170				37
38	SALARIES, WAGES & FEES PAYABLE	2,174,864				38
39	PAYROLL TAXES PAYABLE	1,012				39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME	2,885,489				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	3,746,612				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	10,874,147				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	8,933,433				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	11,771,871				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	20,705,304				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	31,579,451				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	49,316,554				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)	49,316,554				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	80,896,005				60

STATEMENT OF CHANGES IN FUND BALANCES — WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD	46,903,717								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	-1,683,520								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	45,220,197								3
4	ADDITIONS (CREDIT ADJUST-MENTS)	4,096,357								4
5										5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)	4,096,357								10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	49,316,554								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13										13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	49,316,554								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	6,604,145		6,604,145	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)	6,604,145		6,604,145	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	2,570,290		2,570,290	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)	2,570,290		2,570,290	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	9,174,435		9,174,435	17
18	ANCILLARY SERVICES	32,436,500	102,970,478	135,406,978	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	41,610,935	102,970,478	144,581,413	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		50,548,768	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)		50,548,768	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	144,581,413	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	98,347,079	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	46,234,334	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	50,548,768	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-4,314,434	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC)	2,630,914	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,630,914	25
26	TOTAL (LINE 5 PLUS LINE 25)	-1,683,520	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)	-1,683,520	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7173 WORKSHEET H

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTRUCTIONS)							4
5	ADMINISTRATIVE AND GENERAL	265,442				54,574	320,016	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	238,666					238,666	6
7	PHYSICAL THERAPY	93,166					93,166	7
8	OCCUPATIONAL THERAPY	7,674					7,674	8
9	SPEECH PATHOLOGY	987					987	9
10	MEDICAL SOCIAL SERVICES	16,743					16,743	10
11	HOME HEALTH AIDE	4,901					4,901	11
12	SUPPLIES (SEE INSTRUCTIONS)					7,886	7,886	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
24	TOTAL (SUM OF LINES 1-23)	627,579				62,460	690,039	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7173 WORKSHEET H (CONTINUED)

		RECLASS-IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (SEE INSTRUCTIONS)					4
5	ADMINISTRATIVE AND GENERAL	-68,779	251,237		251,237	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		238,666		238,666	6
7	PHYSICAL THERAPY	-93,166				7
8	OCCUPATIONAL THERAPY	-7,674				8
9	SPEECH PATHOLOGY	-987				9
10	MEDICAL SOCIAL SERVICES	-16,743				10
11	HOME HEALTH AIDE		4,901		4,901	11
12	SUPPLIES (SEE INSTRUCTIONS)	-7,886				12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
24	TOTAL (SUM OF LINES 1-23)	-195,235	494,804		494,804	24

COST ALLOCATION - HHA GENERAL SERVICE COST HHA NO.: 14-7173 WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDGS & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION (SEE INSTR.)									4
5	ADMINISTRATIVE AND GENERAL	251,237					251,237	251,237		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	238,666					238,666	246,182	484,848	6
7	PHYSICAL THERAPY									7
8	OCCUPATIONAL THERAPY									8
9	SPEECH PATHOLOGY									9
10	MEDICAL SOCIAL SERVICES									10
11	HOME HEALTH AIDE	4,901					4,901	5,055	9,956	11
12	SUPPLIES (SEE INSTRUCTIONS)									12
13	DRUGS									13
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING									17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
24	TOTAL (SUM OF LINES 1-23)	494,804					494,804		494,804	24

COST ALLOCATION - HHA STATISTICAL BASIS HHA NO.: 14-7173 WORKSHEET H-1 PART II

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTR.)							4
5	ADMINISTRATIVE AND GENERAL					-251,237	487,134	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE					238,666	477,332	6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	HOME HEALTH AIDE					4,901	9,802	11
12	SUPPLIES (SEE INSTRUCTIONS)							12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (SUM OF LINES 1-23)					-7,670	487,134	24
25	COST TO BE ALLOC (PER W/S H)						251,237	25
26	UNIT COST MULTIPLIER						0.515745	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
PART I

	HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE + REPAIRS 6	
1	ADMINISTRATIVE AND GENERAL		19,212	10,149		159,926	189,287	55,812	16,686	1
2	SKILLED NURSING CARE	484,848					484,848	142,959		2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE	9,956					9,956	2,936		7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	494,804	19,212	10,149		159,926	684,091	201,707	16,686	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
PART I

	HHA COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	11	12	13	14	
1	ADMINISTRATIVE AND GENERAL	68,074		11,383		6,266		152,318	7,210	1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	68,074		11,383		6,266		152,318	7,210	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
PART I

	HHA COST CENTER	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	
		15	16	17	19	20	21	22	23	
1	ADMINISTRATIVE AND GENERAL			41,259						1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)			41,259						20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
PART I

	HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP-DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL	548,295		548,295			1
2	SKILLED NURSING CARE	627,807		627,807	537,262	1,165,069	2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE	12,892		12,892	11,033	23,925	7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTAL (SUM OF LINES 1-19)	1,188,994		1,188,994	548,295	1,188,994	20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.				0.855776		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	OTHER CAP REL COSTS NOT USED 3	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 4A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	MAIN-TENANCE + REPAIRS MAINTENANC HOURS 6	OPERATION OF PLANT SQUARE FEET 7	
1	ADMINISTRATIVE AND GENERAL	3,710	7,338		440,230		189,287	7,545	3,710	1
2	SKILLED NURSING CARE						484,848			2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE						9,956			7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)	3,710	7,338		440,230		684,091	7,545	3,710	20
21	TOTAL COST TO BE ALLOCATED	19,212	10,149		159,926		201,707	16,686	68,074	21
22	UNIT COST MULTIPLIER	5.178437						2.211531		22
22	UNIT COST MULTIPLIER		1.383074		0.363278		0.294854		18.348787	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	
1	ADMINISTRATIVE AND GENERAL		270		105		105	654,507		1
2	SKILLED NURSING CARE									2
3	PHYSICAL THERAPY									3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE									7
8	SUPPLIES									8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)		270		105		105	654,507		20
21	TOTAL COST TO BE ALLOCATED		11,383		6,266		152,318	7,210		21
22	UNIT COST MULTIPLIER							0.011016		22
22	UNIT COST MULTIPLIER		42.159259		59.676190		1,450.647619			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7173 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	NURSING SCHOOL ASSIGNED TIME 20	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R PROGRAM COSTS ASSIGNED TIME 22	PARAMED EDUCATION ASSIGNED TIME 23	
1	ADMINISTRATIVE AND GENERAL		1,038						1
2	SKILLED NURSING CARE								2
3	PHYSICAL THERAPY								3
4	OCCUPATIONAL THERAPY								4
5	SPEECH PATHOLOGY								5
6	MEDICAL SOCIAL SERVICES								6
7	HOME HEALTH AIDE								7
8	SUPPLIES								8
9	DRUGS								9
10	DME								10
11	HOME DIALYSIS AIDE SERVICES								11
12	RESPIRATORY THERAPY								12
13	PRIVATE DUTY NURSING								13
14	CLINIC								14
15	HEALTH PROMOTION ACTIVITIES								15
16	DAY CARE PROGRAM								16
17	HOME DELIVERED MEALS PROGRAM								17
18	HOMEMAKER SERVICE								18
19	ALL OTHERS								19
19.50	TELEMEDICINE								19.50
20	TOTAL (SUM OF LINES 1-19)		1,038						20
21	TOTAL COST TO BE ALLOCATED		41,259						21
22	UNIT COST MULTIPLIER								22
22	UNIT COST MULTIPLIER		39.748555						22

APPORTIONMENT OF PATIENT SERVICE COSTS | HHA NO.: 14-7173 | WORKSHEET H-3 PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL VISITS 4	AVERAGE COST PER VISIT (COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	1,165,069		1,165,069	1,672	696.81	1
2	PHYSICAL THERAPY	3		137,870	137,870	937	147.14	2
3	OCCUPATIONAL THERAPY	4		10,650	10,650	100	106.50	3
4	SPEECH PATHOLOGY	5		9,077	9,077	8	1,134.63	4
5	MEDICAL SOCIAL SERVICES	6				97		5
6	HOME HEALTH AIDE	7	23,925		23,925	87	275.00	6
7	TOTAL (SUM OF LINES 1-6)		1,188,994	157,597	1,346,591	2,901		7

	PATIENT SERVICES		
8	SKILLED NURSING CARE		8
8.01	SKILLED NURSING CARE		8.01
9	PHYSICAL THERAPY		9
9.01	PHYSICAL THERAPY		9.01
10	OCCUPATIONAL THERAPY		10
10.01	OCCUPATIONAL THERAPY		10.01
11	SPEECH PATHOLOGY		11
11.01	SPEECH PATHOLOGY		11.01
12	MEDICAL SOCIAL SERVICES		12
12.01	MEDICAL SOCIAL SERVICES		12.01
13	HOME HEALTH AIDE		13
13.01	HOME HEALTH AIDE		13.01
14	TOTAL (SUM OF LINES 8-13)		14

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL CHARGES (FROM HHA RECORD) 4	RATIO (COL.3 ÷ COL.4) 5	
15	COST OF MEDICAL SUPPLIES	8		4,620	4,620	15,849	0.291501	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS — HHA NO.: 14-7173 — WORKSHEET H-3 PARTS I & II (CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			
			PART B			PART B		
	PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL PROGRAM COST (SUM OF COLS.9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	984	688		685,661	479,405		1,165,066	1
2	PHYSICAL THERAPY	547	390		80,486	57,385		137,871	2
3	OCCUPATIONAL THERAPY	76	24		8,094	2,556		10,650	3
4	SPEECH PATHOLOGY	3	5		3,404	5,673		9,077	4
5	MEDICAL SOCIAL SERVICES	44	53						5
6	HOME HEALTH AIDE	71	16		19,525	4,400		23,925	6
7	TOTAL (SUM OF LINES 1-6)	1,725	1,176		797,170	549,419		1,346,589	7

	PATIENT SERVICES	CBSA NO.	PROGRAM VISITS PART A	PROGRAM VISITS PART B NOT SUBJ TO DEDUCTIBLES & COINSUR	PROGRAM VISITS PART B SUBJECT TO DEDUCTIBLES & COINSUR	
		1	2	3	4	
8	SKILLED NURSING CARE	37900	97	31		8
8.01	SKILLED NURSING CARE	99914	887	657		8.01
9	PHYSICAL THERAPY	37900	82	12		9
9.01	PHYSICAL THERAPY	99914	465	378		9.01
10	OCCUPATIONAL THERAPY	37900	25			10
10.01	OCCUPATIONAL THERAPY	99914	51	24		10.01
11	SPEECH PATHOLOGY	37900	1			11
11.01	SPEECH PATHOLOGY	99914	2	5		11.01
12	MEDICAL SOCIAL SERVICES	37900		4		12
12.01	MEDICAL SOCIAL SERVICES	99914	44	49		12.01
13	HOME HEALTH AIDE	37900	10			13
13.01	HOME HEALTH AIDE	99914	61	16		13.01
14	TOTAL (SUM OF LINES 8-13)		1,725	1,176		14

	SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
			PART B			PART B		
	OTHER PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
		6	7	8	9	10	11	
15	COST OF MEDICAL SUPPLIES							15
16	COST OF DRUGS							16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.520265	265,000	137,870	COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY	67	0.345792	30,800	10,650	COL 2, LINE 3	2
3	SPEECH PATHOLOGY	68	0.515745	17,600	9,077	COL 2, LINE 4	3
3.01	AUDIOLOGY	68.01				COL 2, LINE 4	3.01
4	MEDICAL SUPPLIES CHARGED TO PA	71	0.173932	26,564	4,620	COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.283328			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT HHA NO.: 14-7173 WORKSHEET H-4
PARTS I & II

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

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	DESCRIPTION	PART A 1	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
4	AMOUNT 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(B)				4
5	RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
9	PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	291,585	233,269	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	6,921	6,789	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	1,037		14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22	SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	299,543	240,058	22
23	EXCESS REASONABLE COST (FROM LINE 8)			23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	299,543	240,058	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26	NET COST (LINE 24 MINUS LINE 25)	299,543	240,058	26
27	REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	299,543	240,058	29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31	SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	299,543	240,058	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,248	1,389	31.01
32	INTERIM PAYMENTS (SEE INSTRUCTIONS)	298,295	238,669	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7173

WORKSHEET H-5

	DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				298,295		238,669	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 H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)				298,295		238,669	4
		TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		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 (SEE INSTR.)	PROGRAM TO PROVIDER	.01		1,248		1,389	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				299,543		240,058	7

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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK	[ ]	TITLE V	[XX]	HOSPITAL ((14-002)	[XX]	PPS	
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
BOXES	[ ]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	553,992	1
2	CAPITAL DRG OUTLIER PAYMENTS	18,312	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	18.02	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	572,304	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK	[ ]	TITLE V	[XX]	HOSPITAL ((14-002)	[XX]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
BOXES	[XX]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES						21
22	I&R SERVICES-OTHER PRGM COSTS						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
68.01	AUDIOLOGY						68.01
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PA						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	OTTAWA CLINIC						90.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
194	OTHER NONREIMBURSABLE COST						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND						202
	LINES 190-201)						
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4) EXHIBIT 3

	STEP 1: Determine the 3-Year Averaging Period	
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
	STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)	
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
	If this date occurs after the period shown on line 2, stop here and see instructions.	
	STEP 3: Average Pension Contributions During the Averaging Period	
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
	STEP 4: Total Pension Cost for Wage Index	
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19

LOW VOLUME ADJUSTMENT CALCULATION SCHEDULE (For Worksheet E Part A, Lines 70.96 and 70.97) EXHIBIT 4

		Amounts From E Part A (1)	Prior to 10/1/2010 or after 9/30/2013 Pre/Post Entitlement (2)	10/01/2011 through 09/30/2012 (3)	(3.01)	10/01/2012 through 09/30/2013 (4)	(4.01)	(Columns 2 through 4) TOTAL (5)
1	DRG Amounts Other than Outlier Payments	7,016,922		1,584,202		5,432,720		7,016,922 1
2	Outlier payments for discharges	131,826		42,185		89,641		131,826 2
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	285,690		76,403		209,287		285,690 4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT							
5	Amount from Worksheet E Part A, Line 21							5
6	IME payment adjustment							6
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON FOR MME SECTION 422							
7	Amount from Worksheet E Part A, Line 27							7
8	IME add-on adjustment							8
9	Total IME payment							9
	DISPROPORTIONATE SHARE ADJUSTMENT							
10	Allowable disproportionate share percentage	0.0631	0.0631	0.0631	0.0631	0.0631	0.0631	10
11	Disproportionate share adjustment	442,768		99,963		342,805		442,768 11
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES							
12	Total ESRD additional payment							12
13	Subtotal	7,591,516		1,726,350		5,865,166		7,591,516 13
14	Hospital specific payments	9,651,904		2,224,732		7,427,172		9,651,904 14
15	Total payment for inpatient operating costs - E Part A Line 49	9,136,807		2,100,137		7,036,671		9,136,808 15
16	Payment for inpatient program capital	572,304		131,789		440,515		572,304 16
17	Special add-on payments for new technologies							17
18	Capital outlier reconciliation adjustment amount							18
19	SUBTOTAL			2,231,926		7,477,186		9,709,112 19
	CAPITAL PAYMENTS							
20	Capital DRG other than outlier	553,992		126,686		427,306		553,992 20
21	Capital DRG outlier payments	18,312		5,103		13,209		18,312 21
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate							24

	share percentage				
25	Disproportionate share				
25					
	adjustment				
26	Total prospective capital	572,304	131,789	440,515	
572,304	26				
	payments				
	LOW VOLUME ADJUSTMENT				
27	Low volume adjustment factor			0.031250	
27					
28	Low Volume Adjustment				
28					
29	Low Volume Adjustment			233,662	
233,662	29				