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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11-30-2013 TIME: 11:17_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST ANTHONY HOSPTAL (14-0095) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 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	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		97,052	89,496			1
2	SUBPROVIDER - IPF		-1,194				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		95,858	89,496			200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 2875 W. 19TH STREET P.O.BOX: 1

2 CITY: CHICAGO STATE: IL ZIP CODE: 60623 COUNTY: COOK 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ST ANTHONY HOSPTAL	14-0095	16974	1	07/01/1967	N	P	P	3
4	SUBPROVIDER - IPF	PSYCHIATRIC UNIT	14-S095	16974	4	11/01/1988	N	P	P	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012	TO: 06/30/2013							20
21	TYPE OF CONTROL		1							21

INPATIENT PPS INFORMATION

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.	1 Y	2 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.	10,924	1,875				260	24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			38

		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)	N	N	39

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY	N	N	N	46

	CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, 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)

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

		Y/N	IME	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.		Y		70
71 IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		N	N	71
INPATIENT REHABILITATION FACILITY PPS				
75 IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		75
76 IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS				
80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	80
TEFRA PROVIDERS				
85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N	85
86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	86

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.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

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.	N		140

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

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143

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

	DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE V 3	TITLE XIX 4	
155	HOSPITAL	N	N		N	155
156	SUBPROVIDER - IPF	N	N		N	156
157	SUBPROVIDER - IRF	N	N			157
158	SUBPROVIDER - (OTHER)	N	N			158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
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.	N	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.		168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		169
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)		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.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11

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

BED COMPLEMENT

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

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

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

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

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

		Y/N	DATE	
	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: DAVID	LAST NAME: PLETCHER	TITLE: DIR OF REIMBURSEMENT 41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.		42
43	PHONE NUMBER: 773-484-4839	E-MAIL ADDRESS: DPLETCHE@SAINTANTHONYHOSPITAL.	43

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

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	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	94	34,310			4,018	11,312	15,330	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						206			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		94	34,310			4,018	11,312	15,330	7
8	INTENSIVE CARE UNIT	31	15	5,475			1,854	806	2,664	8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43							3,855	13
14	TOTAL (SEE INSTRUCTIONS)		109	39,785			5,872	12,118	21,849	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40	42	15,330			4,110	5,662	11,275	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		151							27
28	OBSERVATION BED DAYS								1,197	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)							941	1,088	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					1,092	4,167	7,279	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						34			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)		2.02	844.74			1,092	4,167	7,279	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40		50.18			379	706	1,286	16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		2.02	894.92						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	48,258,153		48,258,153	1,534,890.00	31.44	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		1,189,449		1,189,449	14,754.00	80.62	4.01
5	PHYSICIAN-PART B		2,664,863		2,664,863	38,994.00	68.34	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		6,214,935		6,214,935	182,243.00	34.10	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		25,307		25,307	423.00	59.83	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)		8,036,652		8,036,652			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		1,105,866		1,105,866			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		81,471		81,471			22.01
23	PHYSICIAN PART B		168,456		168,456			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		549,552		549,552	15,634.00	35.15	26
27	ADMINISTRATIVE & GENERAL		7,548,924		7,548,924	285,461.00	26.44	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		664,828		664,828	4,443.00	149.63	28
29	MAINTENANCE & REPAIRS		361,982		361,982	12,862.00	28.14	29
30	OPERATION OF PLANT		499,047		499,047	21,677.00	23.02	30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING		855,947		855,947	75,628.00	11.32	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)		187,353		187,353	6,500.00	28.82	33
34	DIETARY		866,309	-441,818	424,491	33,741.00	12.58	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			441,818	441,818	35,119.00	12.58	36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		1,093,615		1,093,615	60,706.00	18.01	38
39	CENTRAL SERVICES AND SUPPLY		337,896		337,896	25,045.00	13.49	39
40	PHARMACY		1,034,040		1,034,040	33,913.00	30.49	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		404,951		404,951	16,975.00	23.86	41
42	SOCIAL SERVICE		630,007		630,007	20,562.00	30.64	42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	45,256,022	45,256,022	1,492,085.00	30.33	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	6,214,935	6,214,935	182,243.00	34.10	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	39,041,087	39,041,087	1,309,842.00	29.81	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	25,307	25,307	423.00	59.83	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	8,036,652	8,036,652		20.59%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	47,103,046	47,103,046	1,310,265.00	35.95	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	15,034,451	15,034,451	648,266.00	23.19	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	1,073,278	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	4,180,723	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	171,634	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	62,011	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	117,856	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	3,382,435	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	176,051	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	228,458	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	9,392,446	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	194,740		1
2	HOSPITAL	193,681		2
3	SUBPROVIDER - IPF	1,059		3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA WORKSHEET S-10

	UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION		
1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)	0.253698	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	41,135,284	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	118,836,406	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	30,148,559	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.		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)		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	20,719,506	1,099,234	21,818,740	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	5,256,497	278,873	5,535,370	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	195,852	698,018	893,870	22
23	COST OF CHARITY CARE	5,060,645	-419,145	4,641,500	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)	10,772,088	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	999,911	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	9,772,177	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	2,479,182	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	7,120,682	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	7,120,682	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES — WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFICATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		3,522,839	3,522,839		1
2	00200	CAP REL COSTS-MVBLE EQUIP		123,153	123,153		2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	549,552	6,482,333	7,031,885		4
5.01	00540	COMMUNICATIONS					5.01
5.02	00561	PURCHASING, RECEIVING					5.02
5.03	00571	ADMITTING					5.03
5.04	00581	CASHERING/ACCOUNTS RECEIVABLE					5.04
5.05	00551	DATA PROCESSING					5.05
5.06	00590	ADMINISTRATIVE & GENERAL	7,548,924	15,607,253	23,156,177		5.06
6	00600	MAINTENANCE & REPAIRS	361,982	1,134,091	1,496,073		6
7	00700	OPERATION OF PLANT	499,047	1,300,329	1,799,376		7
8	00800	LAUNDRY & LINEN SERVICE				697,041	8
9	00900	HOUSEKEEPING	855,947	1,002,722	1,858,669		9
10	01000	DIETARY	866,309	1,082,827	1,949,136	-994,060	10
11	01100	CAFETERIA				994,060	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	1,093,615	147,372	1,240,987		13
14	01400	CENTRAL SERVICES & SUPPLY	337,896	543,781	881,677	-697,041	14
15	01500	PHARMACY	1,034,040	3,940,356	4,974,396	-3,645,769	15
16	01600	MEDICAL RECORDS & LIBRARY	404,951	175,813	580,764		16
17	01700	SOCIAL SERVICE	630,007	83,413	713,420		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	1,688,072	1,004,179	2,692,251		22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	5,615,630	875,997	6,491,627		30
31	03100	INTENSIVE CARE UNIT	1,748,384	280,863	2,029,247		31
40	04000	SUBPROVIDER - IPF	2,340,336	311,386	2,651,722		40
43	04300	NURSERY	1,220,925	114,421	1,335,346		43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	1,409,324	2,577,998	3,987,322	-102,344	50
51	05100	RECOVERY ROOM	324,479	33,228	357,707		51
52	05200	DELIVERY ROOM & LABOR ROOM	3,727,774	744,343	4,472,117		52
53	05300	ANESTHESIOLOGY	174,564	987,525	1,162,089		53
54	05400	RADIOLOGY-DIAGNOSTIC	2,121,470	767,035	2,888,505		54
57	05700	CT SCAN	335,183	154,345	489,528		57
58	05800	MRI	113,506	25,851	139,357		58
60	06000	LABORATORY	1,496,588	1,546,750	3,043,338		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	47,609	426,445	474,054		63
65	06500	RESPIRATORY THERAPY	650,161	262,962	913,123		65
66	06600	PHYSICAL THERAPY	912,935	149,205	1,062,140		66
69	06900	ELECTROCARDIOLOGY	432,319	145,786	578,105		69
70	07000	ELECTROENCEPHALOGRAPHY	54,445	8,595	63,040		70
72	07200	IMPL. DEV. CHARGED TO PATIENTS				102,344	72
73	07300	DRUGS CHARGED TO PATIENTS				3,645,769	73
74	07400	RENAL DIALYSIS					74
75	07500	ASC (NON-DISTINCT PART)	273,259	38,632	311,891		75
76	03950	HEMODIALYSIS		267,427	267,427		76
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90	09000	CLINIC	1,186,248	604,503	1,790,751		90
90.01	09001	CHEMOTHERAPY	467,338	104,525	571,863		90.01
90.02	09002	KEDZIE CLINIC	977,221	257,758	1,234,979		90.02
90.03	09003	LITTLE VILLAGE CLINIC	325,418	153,950	479,368		90.03
91	09100	EMERGENCY	2,558,096	679,322	3,237,418		91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	44,383,554	47,669,313	92,052,867		118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	44,523	57,543	102,066		190
192	19200	PHYSICIANS' PRIVATE OFFICES	3,830,076	1,036,463	4,866,539		192
192.01	19210	FUND DEVELOPMENT					192.01
200		TOTAL (SUM OF LINES 118-199)	48,258,153	48,763,319	97,021,472		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	3,522,839	900,245	4,423,084	1
2	00200	CAP REL COSTS-MVBLE EQUIP	123,153		123,153	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	7,031,885	-34	7,031,851	4
5.01	00540	COMMUNICATIONS				5.01
5.02	00561	PURCHASING, RECEIVING				5.02
5.03	00571	ADMITTING				5.03
5.04	00581	CASHERING/ACCOUNTS RECEIVABLE				5.04
5.05	00551	DATA PROCESSING				5.05
5.06	00590	ADMINISTRATIVE & GENERAL	23,156,177	-5,046,807	18,109,370	5.06
6	00600	MAINTENANCE & REPAIRS	1,496,073		1,496,073	6
7	00700	OPERATION OF PLANT	1,799,376		1,799,376	7
8	00800	LAUNDRY & LINEN SERVICE	697,041		697,041	8
9	00900	HOUSEKEEPING	1,858,669		1,858,669	9
10	01000	DIETARY	955,076		955,076	10
11	01100	CAFETERIA	994,060	-531,729	462,331	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	1,240,987	-1,505	1,239,482	13
14	01400	CENTRAL SERVICES & SUPPLY	184,636		184,636	14
15	01500	PHARMACY	1,328,627	-39,990	1,288,637	15
16	01600	MEDICAL RECORDS & LIBRARY	580,764	-797	579,967	16
17	01700	SOCIAL SERVICE	713,420	-20,000	693,420	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	2,692,251	-1,395,470	1,296,781	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	6,491,627	-845,452	5,646,175	30
31	03100	INTENSIVE CARE UNIT	2,029,247		2,029,247	31
40	04000	SUBPROVIDER - IPF	2,651,722		2,651,722	40
43	04300	NURSERY	1,335,346	-697,887	637,459	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	3,884,978	-146,911	3,738,067	50
51	05100	RECOVERY ROOM	357,707		357,707	51
52	05200	DELIVERY ROOM & LABOR ROOM	4,472,117	-1,051,526	3,420,591	52
53	05300	ANESTHESIOLOGY	1,162,089	-149,677	1,012,412	53
54	05400	RADIOLOGY-DIAGNOSTIC	2,888,505	-2,564	2,885,941	54
57	05700	CT SCAN	489,528		489,528	57
58	05800	MRI	139,357		139,357	58
60	06000	LABORATORY	3,043,338	-30,330	3,013,008	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	474,054		474,054	63
65	06500	RESPIRATORY THERAPY	913,123		913,123	65
66	06600	PHYSICAL THERAPY	1,062,140	-89,933	972,207	66
69	06900	ELECTROCARDIOLOGY	578,105		578,105	69
70	07000	ELECTROENCEPHALOGRAPHY	63,040		63,040	70
72	07200	IMPL. DEV. CHARGED TO PATIENTS	102,344		102,344	72
73	07300	DRUGS CHARGED TO PATIENTS	3,645,769		3,645,769	73
74	07400	RENAL DIALYSIS				74
75	07500	ASC (NON-DISTINCT PART)	311,891		311,891	75
76	03950	HEMODIALYSIS	267,427		267,427	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90	09000	CLINIC	1,790,751	-333,618	1,457,133	90
90.01	09001	CHEMOTHERAPY	571,863	-232,953	338,910	90.01
90.02	09002	KEDZIE CLINIC	1,234,979	-542,976	692,003	90.02
90.03	09003	LITTLE VILLAGE CLINIC	479,368	-67,028	412,340	90.03
91	09100	EMERGENCY	3,237,418		3,237,418	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	92,052,867	-10,326,942	81,725,925	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,066		102,066	190
192	19200	PHYSICIANS' PRIVATE OFFICES	4,866,539		4,866,539	192
192.01	19210	FUND DEVELOPMENT				192.01
200		TOTAL (SUM OF LINES 118-199)	97,021,472	-10,326,942	86,694,530	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA RECLASS	B	CAFETERIA	11	441,818	552,242	1
500	TOTAL RECLASSIFICATIONS				441,818	552,242	500
	CODE LETTER - B						
1	COST OF MEDICAL SUPPLIES	C	IMPL. DEV. CHARGED TO PATIENT	72		102,344	1
500	TOTAL RECLASSIFICATIONS					102,344	500
	CODE LETTER - C						
1	COST OF DRUGS SOLD	D	DRUGS CHARGED TO PATIENTS	73		3,645,769	1
500	TOTAL RECLASSIFICATIONS					3,645,769	500
	CODE LETTER - D						
1	RECLASS LAUNDRY COSTS	E	LAUNDRY & LINEN SERVICE	8		697,041	1
500	TOTAL RECLASSIFICATIONS					697,041	500
	CODE LETTER - E						
	GRAND TOTAL (INCREASES)				441,818	4,997,396	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	CAFETERIA RECLASS	B	DIETARY	10	441,818	552,242	1
500	TOTAL RECLASSIFICATIONS				441,818	552,242	500
	CODE LETTER - B						
1	COST OF MEDICAL SUPPLIES	C	OPERATING ROOM	50		102,344	1
500	TOTAL RECLASSIFICATIONS					102,344	500
	CODE LETTER - C						
1	COST OF DRUGS SOLD	D	PHARMACY	15		3,645,769	1
500	TOTAL RECLASSIFICATIONS					3,645,769	500
	CODE LETTER - D						
1	RECLASS LAUNDRY COSTS	E	CENTRAL SERVICES & SUPPLY	14		697,041	1
500	TOTAL RECLASSIFICATIONS					697,041	500
	CODE LETTER - E						
	GRAND TOTAL (DECREASES)				441,818	4,997,396	

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES (1)	ACQUISITIONS PURCHASE (2)	ACQUISITIONS DONATION (3)	ACQUISITIONS TOTAL (4)	DISPOSALS AND RETIREMENTS (5)	ENDING BALANCE (6)	FULLY DEPRECIATED ASSETS (7)	
1	LAND	472,850					472,850		1
2	LAND IMPROVEMENTS	330,859					330,859		2
3	BUILDINGS AND FIXTURES	24,081,925	90,279		90,279	115,703	24,056,501		3
4	BUILDING IMPROVEMENTS	1,961,591	173,865		173,865		2,135,456		4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	27,162,784	5,977,008		5,977,008	38,257	33,101,535		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	54,010,009	6,241,152		6,241,152	153,960	60,097,201		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	54,010,009	6,241,152		6,241,152	153,960	60,097,201		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(1) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	3,522,839						3,522,839	1
2	CAP REL COSTS-MVBLE EQUIP	123,153						123,153	2
3	TOTAL (SUM OF LINES 1-2)	3,645,992						3,645,992	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS (1)	COMPUTATION OF RATIOS CAPITALIZED LEASES (2)	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) (3)	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 DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(2) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	4,423,084						4,423,084	1
2	CAP REL COSTS-MVBLE EQUIP	123,153						123,153	2
3	TOTAL	4,546,237						4,546,237	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,944,276				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-531,729	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-39,990	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33							33
34							34
35	CAPITAL IMPAIRMENT AMORTIZATION	A	900,245	CAP REL COSTS-BLDG & FIXT	1	9	35
36	OTHER REVENUE	B	-4,860,354	ADMINISTRATIVE & GENERAL	5.06		36
36.01	OTHER REVENUE	B	-34	EMPLOYEE BENEFITS DEPARTMENT	4		36.01
36.02	OTHER REVENUE	B	-1,505	NURSING ADMINISTRATION	13		36.02
36.03	OTHER REVENUE	B	-797	MEDICAL RECORDS & LIBRARY	16		36.03
36.04	OTHER REVENUE	B	-20,000	SOCIAL SERVICE	17		36.04
36.08	OTHER REVENUE	B	-1,230,593	I&R SERVICES-OTHER PRGM COSTS A	22		36.08
36.09	OTHER REVENUE	B	-525	ADULTS & PEDIATRICS	30		36.09
37	MILLENIUM BLDG 1ST FLOOR 33% GL	A	-186,453	ADMINISTRATIVE & GENERAL	5.06		37
38	OTHER REVENUE	B	-28,254	DELIVERY ROOM & LABOR ROOM	52		38
39	OTHER REVENUE	B	-2,564	RADIOLOGY-DIAGNOSTIC	54		39
40	OTHER REVENUE	B	-30,330	LABORATORY	60		40
41	OTHER REVENUE	B	-181,182	CLINIC	90		41
42	OTHER REVENUE	B	-153,616	CHEMOTHERAPY	90.01		42
43	OTHER REVENUE	B	-14,985	KEDZIE CLINIC	90.02		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)		-10,326,942				50

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					5

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS — WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	22	I&R SERVICES-OTHER PRGM	AGGREGATE	1,618,997		1,618,997	205,000	14,754	1,454,120	72,706	1
2	30	ADULTS & PEDIATRICS	AGGREGATE	844,927	844,927						2
3	43	NURSERY	AGGREGATE	697,887	697,887						3
4	50	OPERATING ROOM	AGGREGATE	146,911	146,911						4
5	52	DELIVERY ROOM & LABOR RO	AGGREGATE	1,023,272	1,023,272						5
6	53	ANESTHESIOLOGY	AGGREGATE	149,677	149,677						6
7	66	PHYSICAL THERAPY	AGGREGATE	89,933	89,933						7
8	90	CLINIC	AGGREGATE	152,436	152,436						8
9	90.01	CHEMOTHERAPY	AGGREGATE	79,337	79,337						9
10	90.02	KEDZIE CLINIC	AGGREGATE	527,991	527,991						10
11	90.03	LITTLE VILLAGE CLINIC	AGGREGATE	67,028							11
200		TOTAL		5,398,396	3,712,371	1,618,997		14,754	1,454,120	72,706	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
1	22	I&R SERVICES-OTHER PRGM	AGGREGATE					1,454,120	164,877	164,877	1
2	30	ADULTS & PEDIATRICS	AGGREGATE							844,927	2
3	43	NURSERY	AGGREGATE							697,887	3
4	50	OPERATING ROOM	AGGREGATE							146,911	4
5	52	DELIVERY ROOM & LABOR RO	AGGREGATE							1,023,272	5
6	53	ANESTHESIOLOGY	AGGREGATE							149,677	6
7	66	PHYSICAL THERAPY	AGGREGATE							89,933	7
8	90	CLINIC	AGGREGATE							152,436	8
9	90.01	CHEMOTHERAPY	AGGREGATE							79,337	9
10	90.02	KEDZIE CLINIC	AGGREGATE							527,991	10
11	90.03	LITTLE VILLAGE CLINIC	AGGREGATE							67,028	11
200		TOTAL						1,454,120	164,877	3,944,276	200

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	4,423,084	4,423,084				1
2	CAP REL COSTS-MVBLE EQUIP	123,153		123,153			2
4	EMPLOYEE BENEFITS DEPARTMENT	7,031,851	17,395	70	7,049,316		4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	18,109,370	545,639	6,673	1,115,404	19,777,086	5.06
6	MAINTENANCE & REPAIRS	1,496,073	165,285	2,054	53,486	1,716,898	6
7	OPERATION OF PLANT	1,799,376	545,377	11,119	73,738	2,429,610	7
8	LAUNDRY & LINEN SERVICE	697,041	77,110			774,151	8
9	HOUSEKEEPING	1,858,669	39,701	120	126,473	2,024,963	9
10	DIETARY	955,076	190,865	1,002	62,722	1,209,665	10
11	CAFETERIA	462,331			65,282	527,613	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,239,482	77,415	551	161,590	1,479,038	13
14	CENTRAL SERVICES & SUPPLY	184,636	114,148	1,470	49,927	350,181	14
15	PHARMACY	1,288,637	63,120	350	152,788	1,504,895	15
16	MEDICAL RECORDS & LIBRARY	579,967	80,646	486	59,835	720,934	16
17	SOCIAL SERVICE	693,420	21,782		93,089	808,291	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	1,296,781			249,426	1,546,207	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,646,175	919,836	2,832	829,754	7,398,597	30
31	INTENSIVE CARE UNIT	2,029,247	125,148	2,165	258,338	2,414,898	31
40	SUBPROVIDER - IPF	2,651,722	275,155	193	345,803	3,272,873	40
43	NURSERY	637,459	27,675	180	180,401	845,715	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,738,067	126,545	12,756	208,239	4,085,607	50
51	RECOVERY ROOM	357,707			47,944	405,651	51
52	DELIVERY ROOM & LABOR ROOM	3,420,591	84,749	2,173	550,808	4,058,321	52
53	ANESTHESIOLOGY	1,012,412	16,326	6	25,793	1,054,537	53
54	RADIOLOGY-DIAGNOSTIC	2,885,941	234,603	58,825	313,464	3,492,833	54
57	CT SCAN	489,528			49,526	539,054	57
58	MRI	139,357			16,771	156,128	58
60	LABORATORY	3,013,008	155,595	7,539	221,133	3,397,275	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	474,054			7,035	481,089	63
65	RESPIRATORY THERAPY	913,123	28,657	2,022	96,066	1,039,868	65
66	PHYSICAL THERAPY	972,207	37,715	35	134,893	1,144,850	66
69	ELECTROCARDIOLOGY	578,105	21,869	758	63,879	664,611	69
70	ELECTROENCEPHALOGRAPHY	63,040	13,816	353	8,045	85,254	70
72	IMPL. DEV. CHARGED TO PATIENTS	102,344				102,344	72
73	DRUGS CHARGED TO PATIENTS	3,645,769				3,645,769	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	311,891			40,376	352,267	75
76	HEMODIALYSIS	267,427				267,427	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,457,133	131,870	7	175,278	1,764,288	90
90.01	CHEMOTHERAPY	338,910			69,053	407,963	90.01
90.02	KEDZIE CLINIC	692,003			144,392	836,395	90.02
90.03	LITTLE VILLAGE CLINIC	412,340			48,083	460,423	90.03
91	EMERGENCY	3,237,418	81,082	2,454	377,979	3,698,933	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	81,725,925	4,219,124	116,193	6,476,813	80,942,502	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	102,066	3,274	20	6,579	111,939	190
192	PHYSICIANS' PRIVATE OFFICES	4,866,539	200,686	6,940	565,924	5,640,089	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	86,694,530	4,423,084	123,153	7,049,316	86,694,530	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	A+G	MAINTEN-ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.06	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	19,777,086					5.06
6	MAINTENANCE & REPAIRS	507,421	2,224,319				6
7	OPERATION OF PLANT	718,059	328,328	3,475,997			7
8	LAUNDRY & LINEN SERVICE	228,796	46,422	85,106	1,134,475		8
9	HOUSEKEEPING	598,468	23,901	43,818		2,691,150	9
10	DIETARY	357,510	114,904	210,658			10
11	CAFETERIA	155,933					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	437,122	46,606	85,444			13
14	CENTRAL SERVICES & SUPPLY	103,494	68,719	125,986			14
15	PHARMACY	444,764	37,999	69,665			15
16	MEDICAL RECORDS & LIBRARY	213,068	48,550	89,009			16
17	SOCIAL SERVICE	238,886	13,113	24,041			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	456,974				228,450	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,186,592	553,760	1,015,231	589,928	602,907	30
31	INTENSIVE CARE UNIT	713,711	75,341	138,126	113,448	119,925	31
40	SUBPROVIDER - IPF	967,281	165,649	303,690	306,309	241,765	40
43	NURSERY	249,947	16,661	30,545	124,790		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,207,481	76,182	139,668		261,920	50
51	RECOVERY ROOM	119,888					51
52	DELIVERY ROOM & LABOR ROOM	1,199,416	51,020	93,538		545,544	52
53	ANESTHESIOLOGY	311,663	9,828	18,019			53
54	RADIOLOGY-DIAGNOSTIC	1,032,289	141,236	258,933		240,670	54
57	CT SCAN	159,315					57
58	MRI	46,143					58
60	LABORATORY	1,004,048	93,671	171,731		48,335	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	142,183					63
65	RESPIRATORY THERAPY	307,328	17,252	31,629		12,220	65
66	PHYSICAL THERAPY	338,355	22,705	41,626		18,331	66
69	ELECTROCARDIOLOGY	196,422	13,166	24,137		16,142	69
70	ELECTROENCEPHALOGRAPHY	25,196	8,317	15,248			70
72	IMPL. DEV. CHARGED TO PATIENTS	30,247					72
73	DRUGS CHARGED TO PATIENTS	1,077,489				11,035	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	104,111					75
76	HEMODIALYSIS	79,037					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	521,426	79,388	145,546		9,302	90
90.01	CHEMOTHERAPY	120,571				3,466	90.01
90.02	KEDZIE CLINIC	247,192				2,462	90.02
90.03	LITTLE VILLAGE CLINIC	136,076				1,459	90.03
91	EMERGENCY	1,093,201	48,813	89,491		194,160	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	18,077,103	2,101,531	3,250,885	1,134,475	2,558,093	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,083	1,971	3,613		57,181	190
192	PHYSICIANS' PRIVATE OFFICES	1,666,900	120,817	221,499		75,876	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	19,777,086	2,224,319	3,475,997	1,134,475	2,691,150	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	1,892,737					10
11	CAFETERIA		683,546				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		30,045	2,078,255			13
14	CENTRAL SERVICES & SUPPLY		12,393		660,773		14
15	PHARMACY		16,777			2,074,100	15
16	MEDICAL RECORDS & LIBRARY		8,399				16
17	SOCIAL SERVICE		10,180				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		12,279	2,342			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,103,839	106,501	835,478			30
31	INTENSIVE CARE UNIT	217,625	29,242	231,251			31
40	SUBPROVIDER - IPF	571,273	51,649	165,611			40
43	NURSERY		13,576	91,980			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		27,358	91,894			50
51	RECOVERY ROOM		6,289	35,098			51
52	DELIVERY ROOM & LABOR ROOM		57,321	289,454			52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		49,972	6,753			54
57	CT SCAN		8,790				57
58	MRI		4,724				58
60	LABORATORY		37,847				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		968				63
65	RESPIRATORY THERAPY		14,101				65
66	PHYSICAL THERAPY		13,484				66
69	ELECTROCARDIOLOGY		11,229				69
70	ELECTROENCEPHALOGRAPHY		1,523				70
72	IMPL. DEV. CHARGED TO PATIENTS				660,773		72
73	DRUGS CHARGED TO PATIENTS					2,074,100	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)		4,199	18,335			75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		32,731	41,014			90
90.01	CHEMOTHERAPY		7,946				90.01
90.02	KEDZIE CLINIC		10,427				90.02
90.03	LITTLE VILLAGE CLINIC		5,393				90.03
91	EMERGENCY		59,667	253,679			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,892,737	645,010	2,062,889	660,773	2,074,100	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,451				190
192	PHYSICIANS' PRIVATE OFFICES		37,085	15,366			192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,892,737	683,546	2,078,255	660,773	2,074,100	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,079,960					16
17	SOCIAL SERVICE		1,094,511				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			2,246,252			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	107,033	506,547	898,501	15,904,914	-898,501	30
31	INTENSIVE CARE UNIT	31,875	88,026		4,173,468		31
40	SUBPROVIDER - IPF	63,049	372,558		6,481,707		40
43	NURSERY	20,438	127,380		1,521,032		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	80,408			5,970,518		50
51	RECOVERY ROOM	5,287			572,213		51
52	DELIVERY ROOM & LABOR ROOM	45,677			6,340,291		52
53	ANESTHESIOLOGY	34,898			1,428,945		53
54	RADIOLOGY-DIAGNOSTIC	77,486			5,300,172		54
57	CT SCAN	60,872			768,031		57
58	MRI	12,050			219,045		58
60	LABORATORY	92,756			4,845,663		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	11,733			635,973		63
65	RESPIRATORY THERAPY	34,998			1,457,396		65
66	PHYSICAL THERAPY	20,089			1,599,440		66
69	ELECTROCARDIOLOGY	22,819			948,526		69
70	ELECTROENCEPHALOGRAPHY	3,049			138,587		70
72	IMPL. DEV. CHARGED TO PATIENTS	4,578			797,942		72
73	DRUGS CHARGED TO PATIENTS	153,666			6,962,059		73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	8,153			487,065		75
76	HEMODIALYSIS	3,104			349,568		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	11,123		449,250	3,054,068	-449,250	90
90.01	CHEMOTHERAPY	17,753			557,699		90.01
90.02	KEDZIE CLINIC	9,488			1,105,964		90.02
90.03	LITTLE VILLAGE CLINIC	8,398			611,749		90.03
91	EMERGENCY	139,180		898,501	6,475,625	-898,501	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,079,960	1,094,511	2,246,252	78,707,660	-2,246,252	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				209,238		190
192	PHYSICIANS' PRIVATE OFFICES				7,777,632		192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,079,960	1,094,511	2,246,252	86,694,530	-2,246,252	202

COST ALLOCATION - GENERAL SERVICE COSTS | WORKSHEET B PART I

	COST CENTER DESCRIPTION	TOTAL 26	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R 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	15,006,413	30
31	INTENSIVE CARE UNIT	4,173,468	31
40	SUBPROVIDER - IPF	6,481,707	40
43	NURSERY	1,521,032	43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	5,970,518	50
51	RECOVERY ROOM	572,213	51
52	DELIVERY ROOM & LABOR ROOM	6,340,291	52
53	ANESTHESIOLOGY	1,428,945	53
54	RADIOLOGY-DIAGNOSTIC	5,300,172	54
57	CT SCAN	768,031	57
58	MRI	219,045	58
60	LABORATORY	4,845,663	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	635,973	63
65	RESPIRATORY THERAPY	1,457,396	65
66	PHYSICAL THERAPY	1,599,440	66
69	ELECTROCARDIOLOGY	948,526	69
70	ELECTROENCEPHALOGRAPHY	138,587	70
72	IMPL. DEV. CHARGED TO PATIENTS	797,942	72
73	DRUGS CHARGED TO PATIENTS	6,962,059	73
74	RENAL DIALYSIS		74
75	ASC (NON-DISTINCT PART)	487,065	75
76	HEMODIALYSIS	349,568	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	2,604,818	90
90.01	CHEMOTHERAPY	557,699	90.01
90.02	KEDZIE CLINIC	1,105,964	90.02
90.03	LITTLE VILLAGE CLINIC	611,749	90.03
91	EMERGENCY	5,577,124	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
	OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS		94
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	76,461,408	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	209,238	190
192	PHYSICIANS' PRIVATE OFFICES	7,777,632	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	84,448,278	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		17,395	70	17,465	17,465	4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL		545,639	6,673	552,312	2,767	5.06
6	MAINTENANCE & REPAIRS		165,285	2,054	167,339	132	6
7	OPERATION OF PLANT		545,377	11,119	556,496	183	7
8	LAUNDRY & LINEN SERVICE		77,110		77,110		8
9	HOUSEKEEPING		39,701	120	39,821	313	9
10	DIETARY		190,865	1,002	191,867	155	10
11	CAFETERIA					162	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		77,415	551	77,966	400	13
14	CENTRAL SERVICES & SUPPLY		114,148	1,470	115,618	124	14
15	PHARMACY		63,120	350	63,470	378	15
16	MEDICAL RECORDS & LIBRARY		80,646	486	81,132	148	16
17	SOCIAL SERVICE		21,782		21,782	231	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					618	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		919,836	2,832	922,668	2,055	30
31	INTENSIVE CARE UNIT		125,148	2,165	127,313	640	31
40	SUBPROVIDER - IPF		275,155	193	275,348	857	40
43	NURSERY		27,675	180	27,855	447	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		126,545	12,756	139,301	516	50
51	RECOVERY ROOM					119	51
52	DELIVERY ROOM & LABOR ROOM		84,749	2,173	86,922	1,364	52
53	ANESTHESIOLOGY		16,326	6	16,332	64	53
54	RADIOLOGY-DIAGNOSTIC		234,603	58,825	293,428	776	54
57	CT SCAN					123	57
58	MRI					42	58
60	LABORATORY		155,595	7,539	163,134	548	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.					17	63
65	RESPIRATORY THERAPY		28,657	2,022	30,679	238	65
66	PHYSICAL THERAPY		37,715	35	37,750	334	66
69	ELECTROCARDIOLOGY		21,869	758	22,627	158	69
70	ELECTROENCEPHALOGRAPHY		13,816	353	14,169	20	70
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)					100	75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		131,870	7	131,877	434	90
90.01	CHEMOTHERAPY					171	90.01
90.02	KEDZIE CLINIC					358	90.02
90.03	LITTLE VILLAGE CLINIC					119	90.03
91	EMERGENCY		81,082	2,454	83,536	936	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		4,219,124	116,193	4,335,317	16,047	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,274	20	3,294	16	190
192	PHYSICIANS' PRIVATE OFFICES		200,686	6,940	207,626	1,402	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		4,423,084	123,153	4,546,237	17,465	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	A+G	MAINTEN-ANCE AND REPAIRS	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	
		5.06	6	7	8	9	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	555,079					5.06
6	MAINTENANCE & REPAIRS	14,242	181,713				6
7	OPERATION OF PLANT	20,154	26,822	603,655			7
8	LAUNDRY & LINEN SERVICE	6,422	3,792	14,780	102,104		8
9	HOUSEKEEPING	16,797	1,953	7,610		66,494	9
10	DIETARY	10,034	9,387	36,584			10
11	CAFETERIA	4,377					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	12,269	3,807	14,838			13
14	CENTRAL SERVICES & SUPPLY	2,905	5,614	21,879			14
15	PHARMACY	12,483	3,104	12,098			15
16	MEDICAL RECORDS & LIBRARY	5,980	3,966	15,458			16
17	SOCIAL SERVICE	6,705	1,071	4,175			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	12,826				5,645	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	61,367	45,240	176,309	53,095	14,894	30
31	INTENSIVE CARE UNIT	20,032	6,155	23,988	10,210	2,963	31
40	SUBPROVIDER - IPF	27,148	13,532	52,740	27,568	5,974	40
43	NURSERY	7,015	1,361	5,305	11,231		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	33,890	6,224	24,255		6,472	50
51	RECOVERY ROOM	3,365					51
52	DELIVERY ROOM & LABOR ROOM	33,664	4,168	16,244		13,480	52
53	ANESTHESIOLOGY	8,747	803	3,129			53
54	RADIOLOGY-DIAGNOSTIC	28,973	11,538	44,967		5,947	54
57	CT SCAN	4,471					57
58	MRI	1,295					58
60	LABORATORY	28,180	7,652	29,823		1,194	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,991					63
65	RESPIRATORY THERAPY	8,626	1,409	5,493		302	65
66	PHYSICAL THERAPY	9,497	1,855	7,229		453	66
69	ELECTROCARDIOLOGY	5,513	1,076	4,192		399	69
70	ELECTROENCEPHALOGRAPHY	707	679	2,648			70
72	IMPL. DEV. CHARGED TO PATIENTS	849					72
73	DRUGS CHARGED TO PATIENTS	30,242				273	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	2,922					75
76	HEMODIALYSIS	2,218					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	14,635	6,486	25,276		230	90
90.01	CHEMOTHERAPY	3,384				86	90.01
90.02	KEDZIE CLINIC	6,938				61	90.02
90.03	LITTLE VILLAGE CLINIC	3,819				36	90.03
91	EMERGENCY	30,683	3,988	15,541		4,797	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	507,365	171,682	564,561	102,104	63,206	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	929	161	628		1,413	190
192	PHYSICIANS' PRIVATE OFFICES	46,785	9,870	38,466		1,875	192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	555,079	181,713	603,655	102,104	66,494	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10	11	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY	248,027					10
11	CAFETERIA		4,539				11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		200	109,480			13
14	CENTRAL SERVICES & SUPPLY		82		146,222		14
15	PHARMACY		111			91,644	15
16	MEDICAL RECORDS & LIBRARY		56				16
17	SOCIAL SERVICE		68				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		82	123			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	144,649	706	44,013			30
31	INTENSIVE CARE UNIT	28,518	194	12,182			31
40	SUBPROVIDER - IPF	74,860	343	8,724			40
43	NURSERY		90	4,845			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		182	4,841			50
51	RECOVERY ROOM		42	1,849			51
52	DELIVERY ROOM & LABOR ROOM		381	15,248			52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		332	356			54
57	CT SCAN		58				57
58	MRI		31				58
60	LABORATORY		251				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		6				63
65	RESPIRATORY THERAPY		94				65
66	PHYSICAL THERAPY		90				66
69	ELECTROCARDIOLOGY		75				69
70	ELECTROENCEPHALOGRAPHY		10				70
72	IMPL. DEV. CHARGED TO PATIENTS				146,222		72
73	DRUGS CHARGED TO PATIENTS					91,644	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)		28	966			75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		217	2,161			90
90.01	CHEMOTHERAPY		53				90.01
90.02	KEDZIE CLINIC		69				90.02
90.03	LITTLE VILLAGE CLINIC		36				90.03
91	EMERGENCY		396	13,363			91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	248,027	4,283	108,671	146,222	91,644	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		10				190
192	PHYSICIANS' PRIVATE OFFICES		246	809			192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	248,027	4,539	109,480	146,222	91,644	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I/R-OTHER PROGRAM COSTS 22	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	106,740					16
17	SOCIAL SERVICE		34,032				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			19,294			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,575	15,750		1,491,321		30
31	INTENSIVE CARE UNIT	3,149	2,737		238,081		31
40	SUBPROVIDER - IPF	6,229	11,584		504,907		40
43	NURSERY	2,019	3,961		64,129		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	7,944			223,625		50
51	RECOVERY ROOM	522			5,897		51
52	DELIVERY ROOM & LABOR ROOM	4,513			175,984		52
53	ANESTHESIOLOGY	3,448			32,523		53
54	RADIOLOGY-DIAGNOSTIC	7,656			393,973		54
57	CT SCAN	6,014			10,666		57
58	MRI	1,191			2,559		58
60	LABORATORY	9,164			239,946		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,159			5,173		63
65	RESPIRATORY THERAPY	3,458			50,299		65
66	PHYSICAL THERAPY	1,985			59,193		66
69	ELECTROCARDIOLOGY	2,255			36,295		69
70	ELECTROENCEPHALOGRAPHY	301			18,534		70
72	IMPL. DEV. CHARGED TO PATIENTS	452			147,523		72
73	DRUGS CHARGED TO PATIENTS	15,222			137,381		73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	806			4,822		75
76	HEMODIALYSIS	307			2,525		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,099			182,415		90
90.01	CHEMOTHERAPY	1,754			5,448		90.01
90.02	KEDZIE CLINIC	937			8,363		90.02
90.03	LITTLE VILLAGE CLINIC	830			4,840		90.03
91	EMERGENCY	13,751			166,991		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	106,740	34,032		4,213,413		118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				6,451		190
192	PHYSICIANS' PRIVATE OFFICES				307,079		192
192.01	FUND DEVELOPMENT						192.01
200	CROSS FOOT ADJUSTMENTS			19,294	19,294		200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	106,740	34,032	19,294	4,546,237		202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B, PART II

	COST CENTER DESCRIPTION	TOTAL (26)	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS DEPARTMENT		4
5.01	COMMUNICATIONS		5.01
5.02	PURCHASING, RECEIVING		5.02
5.03	ADMITTING		5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE		5.04
5.05	DATA PROCESSING		5.05
5.06	ADMINISTRATIVE & GENERAL		5.06
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R 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	1,491,321	30
31	INTENSIVE CARE UNIT	238,081	31
40	SUBPROVIDER - IPF	504,907	40
43	NURSERY	64,129	43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	223,625	50
51	RECOVERY ROOM	5,897	51
52	DELIVERY ROOM & LABOR ROOM	175,984	52
53	ANESTHESIOLOGY	32,523	53
54	RADIOLOGY-DIAGNOSTIC	393,973	54
57	CT SCAN	10,666	57
58	MRI	2,559	58
60	LABORATORY	239,946	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,173	63
65	RESPIRATORY THERAPY	50,299	65
66	PHYSICAL THERAPY	59,193	66
69	ELECTROCARDIOLOGY	36,295	69
70	ELECTROENCEPHALOGRAPHY	18,534	70
72	IMPL. DEV. CHARGED TO PATIENTS	147,523	72
73	DRUGS CHARGED TO PATIENTS	137,381	73
74	RENAL DIALYSIS		74
75	ASC (NON-DISTINCT PART)	4,822	75
76	HEMODIALYSIS	2,525	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90	CLINIC	182,415	90
90.01	CHEMOTHERAPY	5,448	90.01
90.02	KEDZIE CLINIC	8,363	90.02
90.03	LITTLE VILLAGE CLINIC	4,840	90.03
91	EMERGENCY	166,991	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
	OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS		94
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	4,213,413	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,451	190
192	PHYSICIANS' PRIVATE OFFICES	307,079	192
192.01	FUND DEVELOPMENT		192.01
200	CROSS FOOT ADJUSTMENTS	19,294	200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	4,546,237	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET) 1	NEW CAP-REL COSTS MOV EQUIP DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A.06	A+G ACCUM COST 5.06	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	202,656					1
2	CAP REL COSTS-MVBLE EQUIP		1,656,033				2
4	EMPLOYEE BENEFITS DEPARTMENT	797	935	47,708,601			4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL	25,000	89,727	7,548,924	-19,777,086	66,917,444	5.06
6	MAINTENANCE & REPAIRS	7,573	27,614	361,982		1,716,898	6
7	OPERATION OF PLANT	24,988	149,517	499,047		2,429,610	7
8	LAUNDRY & LINEN SERVICE	3,533				774,151	8
9	HOUSEKEEPING	1,819	1,618	855,947		2,024,963	9
10	DIETARY	8,745	13,477	424,491		1,209,665	10
11	CAFETERIA			441,818		527,613	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,547	7,408	1,093,615		1,479,038	13
14	CENTRAL SERVICES & SUPPLY	5,230	19,763	337,896		350,181	14
15	PHARMACY	2,892	4,702	1,034,040		1,504,895	15
16	MEDICAL RECORDS & LIBRARY	3,695	6,537	404,951		720,934	16
17	SOCIAL SERVICE	998		630,007		808,291	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			1,688,072		1,546,207	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	42,145	38,081	5,615,630		7,398,597	30
31	INTENSIVE CARE UNIT	5,734	29,115	1,748,384		2,414,898	31
40	SUBPROVIDER - IPF	12,607	2,592	2,340,336		3,272,873	40
43	NURSERY	1,268	2,426	1,220,925		845,715	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,798	171,529	1,409,324		4,085,607	50
51	RECOVERY ROOM			324,479		405,651	51
52	DELIVERY ROOM & LABOR ROOM	3,883	29,224	3,727,774		4,058,321	52
53	ANESTHESIOLOGY	748	77	174,564		1,054,537	53
54	RADIOLOGY-DIAGNOSTIC	10,749	791,050	2,121,470		3,492,833	54
57	CT SCAN			335,183		539,054	57
58	MRI			113,506		156,128	58
60	LABORATORY	7,129	101,380	1,496,588		3,397,275	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.			47,609		481,089	63
65	RESPIRATORY THERAPY	1,313	27,190	650,161		1,039,868	65
66	PHYSICAL THERAPY	1,728	469	912,935		1,144,850	66
69	ELECTROCARDIOLOGY	1,002	10,188	432,319		664,611	69
70	ELECTROENCEPHALOGRAPHY	633	4,744	54,445		85,254	70
72	IMPL. DEV. CHARGED TO PATIENTS					102,344	72
73	DRUGS CHARGED TO PATIENTS					3,645,769	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)			273,259		352,267	75
76	HEMODIALYSIS					267,427	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	6,042	92	1,186,248		1,764,288	90
90.01	CHEMOTHERAPY			467,338		407,963	90.01
90.02	KEDZIE CLINIC			977,221		836,395	90.02
90.03	LITTLE VILLAGE CLINIC			325,418		460,423	90.03
91	EMERGENCY	3,715	32,994	2,558,096		3,698,933	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	193,311	1,562,449	43,834,002	-19,777,086	61,165,416	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	264	44,523		111,939	190
192	PHYSICIANS' PRIVATE OFFICES	9,195	93,320	3,830,076		5,640,089	192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET) 1	NEW CAP-REL COSTS MOV EQUIP DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A.06	A+G ACCUM COST 5.06	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	4,423,084	123,153	7,049,316		19,777,086	202
203	UNIT COST MULT-WS B PT I	21.825576	0.074366	0.147758		0.295545	203
204	COST TO BE ALLOC PER B PT II			17,465		555,079	204
205	UNIT COST MULT-WS B PT II			0.000366		0.008295	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAINTEN-ANCE AND REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS	169,286					6
7	OPERATION OF PLANT	24,988	144,298				7
8	LAUNDRY & LINEN SERVICE	3,533	3,533	680,476			8
9	HOUSEKEEPING	1,819	1,819		29,509		9
10	DIETARY	8,745	8,745			92,130	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,547	3,547				13
14	CENTRAL SERVICES & SUPPLY	5,230	5,230				14
15	PHARMACY	2,892	2,892				15
16	MEDICAL RECORDS & LIBRARY	3,695	3,695				16
17	SOCIAL SERVICE	998	998				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				2,505		22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	42,145	42,145	353,848	6,611	53,730	30
31	INTENSIVE CARE UNIT	5,734	5,734	68,048	1,315	10,593	31
40	SUBPROVIDER - IPF	12,607	12,607	183,729	2,651	27,807	40
43	NURSERY	1,268	1,268	74,851			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,798	5,798		2,872		50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM	3,883	3,883		5,982		52
53	ANESTHESIOLOGY	748	748				53
54	RADIOLOGY-DIAGNOSTIC	10,749	10,749		2,639		54
57	CT SCAN						57
58	MRI						58
60	LABORATORY	7,129	7,129		530		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
65	RESPIRATORY THERAPY	1,313	1,313		134		65
66	PHYSICAL THERAPY	1,728	1,728		201		66
69	ELECTROCARDIOLOGY	1,002	1,002		177		69
70	ELECTROENCEPHALOGRAPHY	633	633				70
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS				121		73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)						75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	6,042	6,042		102		90
90.01	CHEMOTHERAPY				38		90.01
90.02	KEDZIE CLINIC				27		90.02
90.03	LITTLE VILLAGE CLINIC				16		90.03
91	EMERGENCY	3,715	3,715		2,129		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	159,941	134,953	680,476	28,050	92,130	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150		627		190
192	PHYSICIANS' PRIVATE OFFICES	9,195	9,195		832		192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAINTEN-ANCE AND REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE PATIENT DAYS 8	HOUSE-KEEPING (HOURS OF SERVICE) 9	DIETARY (MEALS SERVED) 10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	2,224,319	3,475,997	1,134,475	2,691,150	1,892,737	202
203	UNIT COST MULT-WS B PT I	13.139415	24.089017	1.667179	91.197601	20.544198	203
204	COST TO BE ALLOC PER B PT II	181,713	603,655	102,104	66,494	248,027	204
205	UNIT COST MULT-WS B PT II	1.073408	4.183391	0.150048	2.253346	2.692142	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA FULL TIME HOURS 11	NURSING ADMINI-STRATION (FULL TIME TIME) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	66,410					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,919	745,375				13
14	CENTRAL SERVICES & SUPPLY	1,204		10,000			14
15	PHARMACY	1,630			10,000		15
16	MEDICAL RECORDS & LIBRARY	816				301,388,100	16
17	SOCIAL SERVICE	989					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	1,193	840				22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,347	299,648			29,872,332	30
31	INTENSIVE CARE UNIT	2,841	82,939			8,896,131	31
40	SUBPROVIDER - IPF	5,018	59,397			17,596,825	40
43	NURSERY	1,319	32,989			5,704,270	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,658	32,958			22,441,544	50
51	RECOVERY ROOM	611	12,588			1,475,684	51
52	DELIVERY ROOM & LABOR ROOM	5,569	103,814			12,748,128	52
53	ANESTHESIOLOGY					9,739,802	53
54	RADIOLOGY-DIAGNOSTIC	4,855	2,422			21,625,895	54
57	CT SCAN	854				16,989,146	57
58	MRI	459				3,363,108	58
60	LABORATORY	3,677				25,887,672	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	94				3,274,723	63
65	RESPIRATORY THERAPY	1,370				9,767,851	65
66	PHYSICAL THERAPY	1,310				5,606,837	66
69	ELECTROCARDIOLOGY	1,091				6,368,681	69
70	ELECTROENCEPHALOGRAPHY	148				851,051	70
72	IMPL. DEV. CHARGED TO PATIENTS			10,000		1,277,612	72
73	DRUGS CHARGED TO PATIENTS				10,000	42,863,077	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	408	6,576			2,275,558	75
76	HEMODIALYSIS					866,440	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	3,180	14,710			3,104,381	90
90.01	CHEMOTHERAPY	772				4,954,882	90.01
90.02	KEDZIE CLINIC	1,013				2,648,050	90.02
90.03	LITTLE VILLAGE CLINIC	524				2,343,821	90.03
91	EMERGENCY	5,797	90,983			38,844,599	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	62,666	739,864	10,000	10,000	301,388,100	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	141					190
192	PHYSICIANS' PRIVATE OFFICES	3,603	5,511				192
192.01	FUND DEVELOPMENT						192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAFETERIA FULL TIME HOURS 11	NURSING ADMINI-STRATION (FULL TIME TIME) 13	CENTRAL SERVICES & SUPPLY (COSTED REQUIS) 14	PHARMACY (COSTED REQUIS) 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	683,546	2,078,255	660,773	2,074,100	1,079,960	202
203	UNIT COST MULT-WS B PT I	10.292817	2.788201	66.077300	207.410000	0.003583	203
204	COST TO BE ALLOC PER B PT II	4,539	109,480	146,222	91,644	106,740	204
205	UNIT COST MULT-WS B PT II	0.068348	0.146879	14.622200	9.164400	0.000354	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
	GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT			1
2	CAP REL COSTS-MVBLE EQUIP			2
4	EMPLOYEE BENEFITS DEPARTMENT			4
5.01	COMMUNICATIONS			5.01
5.02	PURCHASING, RECEIVING			5.02
5.03	ADMITTING			5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE			5.04
5.05	DATA PROCESSING			5.05
5.06	ADMINISTRATIVE & GENERAL			5.06
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
12	MAINTENANCE OF PERSONNEL			12
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE	33,124		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		1,000	22
23	PARAMED ED PRGM-(SPECIFY)			23
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	15,330	400	30
31	INTENSIVE CARE UNIT	2,664		31
40	SUBPROVIDER - IPF	11,275		40
43	NURSERY	3,855		43
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM			50
51	RECOVERY ROOM			51
52	DELIVERY ROOM & LABOR ROOM			52
53	ANESTHESIOLOGY			53
54	RADIOLOGY-DIAGNOSTIC			54
57	CT SCAN			57
58	MRI			58
60	LABORATORY			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63	BLOOD STORING, PROCESSING & TRANS.			63
65	RESPIRATORY THERAPY			65
66	PHYSICAL THERAPY			66
69	ELECTROCARDIOLOGY			69
70	ELECTROENCEPHALOGRAPHY			70
72	IMPL. DEV. CHARGED TO PATIENTS			72
73	DRUGS CHARGED TO PATIENTS			73
74	RENAL DIALYSIS			74
75	ASC (NON-DISTINCT PART)			75
76	HEMODIALYSIS			76
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	OUTPATIENT SERVICE COST CENTERS			
90	CLINIC		200	90
90.01	CHEMOTHERAPY			90.01
90.02	KEDZIE CLINIC			90.02
90.03	LITTLE VILLAGE CLINIC			90.03
91	EMERGENCY		400	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
	OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS			94
99.10	CORF			99.10
99.20	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	OUTPATIENT SPEECH PATHOLOGY			99.40
	SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	33,124	1,000	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192	PHYSICIANS' PRIVATE OFFICES			192
192.01	FUND DEVELOPMENT			192.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	SOCIAL SERVICE PATIENT DAYS 17	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22	
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	1,094,511	2,246,252	202
203	UNIT COST MULT-WS B PT I	33.042839	2,246.252000	203
204	COST TO BE ALLOC PER B PT II	34,032	19,294	204
205	UNIT COST MULT-WS B PT II	1.027412	19.294000	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	15,006,413		15,006,413		15,006,413	30
31	INTENSIVE CARE UNIT	4,173,468		4,173,468		4,173,468	31
40	SUBPROVIDER - IPF	6,481,707		6,481,707		6,481,707	40
43	NURSERY	1,521,032		1,521,032		1,521,032	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,970,518		5,970,518		5,970,518	50
51	RECOVERY ROOM	572,213		572,213		572,213	51
52	DELIVERY ROOM & LABOR ROOM	6,340,291		6,340,291		6,340,291	52
53	ANESTHESIOLOGY	1,428,945		1,428,945		1,428,945	53
54	RADIOLOGY-DIAGNOSTIC	5,300,172		5,300,172		5,300,172	54
57	CT SCAN	768,031		768,031		768,031	57
58	MRI	219,045		219,045		219,045	58
60	LABORATORY	4,845,663		4,845,663		4,845,663	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
63	BLOOD STORING, PROCESSING &	635,973		635,973		635,973	63
65	RESPIRATORY THERAPY	1,457,396		1,457,396		1,457,396	65
66	PHYSICAL THERAPY	1,599,440		1,599,440		1,599,440	66
69	ELECTROCARDIOLOGY	948,526		948,526		948,526	69
70	ELECTROENCEPHALOGRAPHY	138,587		138,587		138,587	70
72	IMPL. DEV. CHARGED TO PATIE	797,942		797,942		797,942	72
73	DRUGS CHARGED TO PATIENTS	6,962,059		6,962,059		6,962,059	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	487,065		487,065		487,065	75
76	HEMODIALYSIS	349,568		349,568		349,568	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,604,818		2,604,818		2,604,818	90
90.01	CHEMOTHERAPY	557,699		557,699		557,699	90.01
90.02	KEDZIE CLINIC	1,105,964		1,105,964		1,105,964	90.02
90.03	LITTLE VILLAGE CLINIC	611,749		611,749		611,749	90.03
91	EMERGENCY	5,577,124		5,577,124		5,577,124	91
92	OBSERVATION BEDS (NON-DISTI	1,086,864		1,086,864		1,086,864	92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	77,548,272		77,548,272		77,548,272	200
201	LESS OBSERVATION BEDS	1,086,864		1,086,864		1,086,864	201
202	TOTAL (SEE INSTRUCTIONS)	76,461,408		76,461,408		76,461,408	202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT	CHARGES OUTPATIENT	TOTAL (COLS. 6 + 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	28,013,724		28,013,724				30
31	INTENSIVE CARE UNIT	8,896,131		8,896,131				31
40	SUBPROVIDER - IPF	17,596,825		17,596,825				40
43	NURSERY	5,704,270		5,704,270				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	9,917,735	12,523,809	22,441,544	0.266048	0.266048	0.266048	50
51	RECOVERY ROOM	439,705	1,035,979	1,475,684	0.387761	0.387761	0.387761	51
52	DELIVERY ROOM & LABOR ROOM	10,092,931	2,655,197	12,748,128	0.497351	0.497351	0.497351	52
53	ANESTHESIOLOGY	3,848,950	5,890,852	9,739,802	0.146712	0.146712	0.146712	53
54	RADIOLOGY-DIAGNOSTIC	4,615,123	17,010,772	21,625,895	0.245085	0.245085	0.245085	54
57	CT SCAN	5,286,895	11,702,251	16,989,146	0.045207	0.045207	0.045207	57
58	MRI	511,047	2,852,061	3,363,108	0.065132	0.065132	0.065132	58
60	LABORATORY	13,172,212	12,715,460	25,887,672	0.187180	0.187180	0.187180	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
63	BLOOD STORING, PROCESSING &	2,766,213	508,510	3,274,723	0.194207	0.194207	0.194207	63
65	RESPIRATORY THERAPY	9,329,978	437,873	9,767,851	0.149203	0.149203	0.149203	65
66	PHYSICAL THERAPY	500,112	5,106,725	5,606,837	0.285266	0.285266	0.285266	66
69	ELECTROCARDIOLOGY	2,638,131	3,730,550	6,368,681	0.148936	0.148936	0.148936	69
70	ELECTROENCEPHALOGRAPHY	195,091	655,960	851,051	0.162842	0.162842	0.162842	70
72	IMPL. DEV. CHARGED TO PATIE	789,671	487,941	1,277,612	0.624557	0.624557	0.624557	72
73	DRUGS CHARGED TO PATIENTS	21,910,438	20,952,639	42,863,077	0.162426	0.162426	0.162426	73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)	85,062	2,190,496	2,275,558	0.214042	0.214042	0.214042	75
76	HEMODIALYSIS	842,045	24,395	866,440	0.403453	0.403453	0.403453	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	463	3,103,918	3,104,381	0.839078	0.839078	0.839078	90
90.01	CHEMOTHERAPY	222	4,954,660	4,954,882	0.112555	0.112555	0.112555	90.01
90.02	KEDZIE CLINIC		2,648,050	2,648,050	0.417652	0.417652	0.417652	90.02
90.03	LITTLE VILLAGE CLINIC		2,343,821	2,343,821	0.261005	0.261005	0.261005	90.03
91	EMERGENCY	7,184,984	31,659,615	38,844,599	0.143575	0.143575	0.143575	91
92	OBSERVATION BEDS (NON-DISTI		1,858,608	1,858,608	0.584773	0.584773	0.584773	92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	154,337,958	147,050,142	301,388,100				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	154,337,958	147,050,142	301,388,100				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	1,491,321		1,491,321	16,527	90.24	4,018	362,584	30
31	INTENSIVE CARE UNIT	238,081		238,081	2,664	89.37	1,854	165,692	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	504,907		504,907	11,275	44.78	4,110	184,046	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	64,129		64,129	3,855	16.64			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	2,298,438		2,298,438	34,321		9,982	712,322	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 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	223,625	22,441,544	0.009965	2,413,231	24,048	50
51	RECOVERY ROOM	5,897	1,475,684	0.003996	125,275	501	51
52	DELIVERY ROOM & LABOR ROOM	175,984	12,748,128	0.013805	4,166	58	52
53	ANESTHESIOLOGY	32,523	9,739,802	0.003339	742,466	2,479	53
54	RADIOLOGY-DIAGNOSTIC	393,973	21,625,895	0.018218	1,818,913	33,137	54
57	CT SCAN	10,666	16,989,146	0.000628	1,378,643	866	57
58	MRI	2,559	3,363,108	0.000761	176,894	135	58
60	LABORATORY	239,946	25,887,672	0.009269	3,603,439	33,400	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	5,173	3,274,723	0.001580	647,051	1,022	63
65	RESPIRATORY THERAPY	50,299	9,767,851	0.005149	3,529,569	18,174	65
66	PHYSICAL THERAPY	59,193	5,606,837	0.010557	268,526	2,835	66
69	ELECTROCARDIOLOGY	36,295	6,368,681	0.005699	1,144,533	6,523	69
70	ELECTROENCEPHALOGRAPHY	18,534	851,051	0.021778	81,122	1,767	70
72	IMPL. DEV. CHARGED TO PATIENT	147,523	1,277,612	0.115468	411,794	47,549	72
73	DRUGS CHARGED TO PATIENTS	137,381	42,863,077	0.003205	6,654,819	21,329	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	4,822	2,275,558	0.002119	25,034	53	75
76	HEMODIALYSIS	2,525	866,440	0.002914	507,822	1,480	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	182,415	3,104,381	0.058761			90
90.01	CHEMOTHERAPY	5,448	4,954,882	0.001100			90.01
90.02	KEDZIE CLINIC	8,363	2,648,050	0.003158			90.02
90.03	LITTLE VILLAGE CLINIC	4,840	2,343,821	0.002065			90.03
91	EMERGENCY	166,991	38,844,599	0.004299	1,792,478	7,706	91
92	OBSERVATION BEDS (NON-DISTINC	108,011	1,858,608	0.058114			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	2,022,986	241,177,150		25,325,775	203,062	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	16,527		4,018		30
31	INTENSIVE CARE UNIT	2,664		1,854		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	11,275		4,110		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	3,855				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	34,321		9,982		200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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] TITLE XVIII-PT A [ ] TITLE XIX
[XX] HOSPITAL (14-0095) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF [ ] NF
[ ] ICF/MR
[XX] PPS [ ] TEFRA

	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	22,441,544			2,413,231		2,445,385		50
51	RECOVERY ROOM	1,475,684			125,275		224,224		51
52	DELIVERY ROOM & LABOR ROOM	12,748,128			4,166		2,968		52
53	ANESTHESIOLOGY	9,739,802			742,466		1,262,203		53
54	RADIOLOGY-DIAGNOSTIC	21,625,895			1,818,913		2,117,286		54
57	CT SCAN	16,989,146			1,378,643		2,032,682		57
58	MRI	3,363,108			176,894		489,945		58
60	LABORATORY	25,887,672			3,603,439		239,318		60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,274,723			647,051		71,281		63
65	RESPIRATORY THERAPY	9,767,851			3,529,569		400,000		65
66	PHYSICAL THERAPY	5,606,837			268,526		32,646		66
69	ELECTROCARDIOLOGY	6,368,681			1,144,533		1,170,967		69
70	ELECTROENCEPHALOGRAPHY	851,051			81,122		152,104		70
72	IMPL. DEV. CHARGED TO PATIEN	1,277,612			411,794		105,108		72
73	DRUGS CHARGED TO PATIENTS	42,863,077			6,654,819		8,536,849		73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	2,275,558			25,034		510,327		75
76	HEMODIALYSIS	866,440			507,822		14,350		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,104,381					1,298,950		90
90.01	CHEMOTHERAPY	4,954,882					2,334,883		90.01
90.02	KEDZIE CLINIC	2,648,050					21,633		90.02
90.03	LITTLE VILLAGE CLINIC	2,343,821							90.03
91	EMERGENCY	38,844,599			1,792,478		2,042,446		91
92	OBSERVATION BEDS (NON-DISTIN	1,858,608					502,464		92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	241,177,150			25,325,775		26,008,019		200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.266048	2,445,385			650,590			50
51	RECOVERY ROOM	0.387761	224,224			86,945			51
52	DELIVERY ROOM & LABOR ROOM	0.497351	2,968			1,476			52
53	ANESTHESIOLOGY	0.146712	1,262,203			185,180			53
54	RADIOLOGY-DIAGNOSTIC	0.245085	2,117,286			518,915			54
57	CT SCAN	0.045207	2,032,682			91,891			57
58	MRI	0.065132	489,945			31,911			58
60	LABORATORY	0.187180	239,318			44,796			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207	71,281			13,843			63
65	RESPIRATORY THERAPY	0.149203	400,000			59,681			65
66	PHYSICAL THERAPY	0.285266	32,646			9,313			66
69	ELECTROCARDIOLOGY	0.148936	1,170,967			174,399			69
70	ELECTROENCEPHALOGRAPHY	0.162842	152,104			24,769			70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557	105,108			65,646			72
73	DRUGS CHARGED TO PATIENTS	0.162426	8,536,849		33,102	1,386,606		5,377	73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	0.214042	510,327			109,231			75
76	HEMODIALYSIS	0.403453	14,350			5,790			76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.839078	1,298,950			1,089,920			90
90.01	CHEMOTHERAPY	0.112555	2,334,883			262,803			90.01
90.02	KEDZIE CLINIC	0.417652	21,633			9,035			90.02
90.03	LITTLE VILLAGE CLINIC	0.261005							90.03
91	EMERGENCY	0.143575	2,042,446			293,244			91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773	502,464			293,827			92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)		26,008,019		33,102	5,409,811		5,377	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		26,008,019		33,102	5,409,811		5,377	202

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	223,625	22,441,544	0.009965	24,473	244	50
51	RECOVERY ROOM	5,897	1,475,684	0.003996	1,704	7	51
52	DELIVERY ROOM & LABOR ROOM	175,984	12,748,128	0.013805			52
53	ANESTHESIOLOGY	32,523	9,739,802	0.003339	10,422	35	53
54	RADIOLOGY-DIAGNOSTIC	393,973	21,625,895	0.018218	53,505	975	54
57	CT SCAN	10,666	16,989,146	0.000628	65,464	41	57
58	MRI	2,559	3,363,108	0.000761	10,266	8	58
60	LABORATORY	239,946	25,887,672	0.009269	543,747	5,040	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	5,173	3,274,723	0.001580	25,979	41	63
65	RESPIRATORY THERAPY	50,299	9,767,851	0.005149	197,760	1,018	65
66	PHYSICAL THERAPY	59,193	5,606,837	0.010557	5,799	61	66
69	ELECTROCARDIOLOGY	36,295	6,368,681	0.005699	97,143	554	69
70	ELECTROENCEPHALOGRAPHY	18,534	851,051	0.021778	18,612	405	70
72	IMPL. DEV. CHARGED TO PATIENT	147,523	1,277,612	0.115468			72
73	DRUGS CHARGED TO PATIENTS	137,381	42,863,077	0.003205	1,260,833	4,041	73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	4,822	2,275,558	0.002119	340	1	75
76	HEMODIALYSIS	2,525	866,440	0.002914	25,830	75	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	182,415	3,104,381	0.058761			90
90.01	CHEMOTHERAPY	5,448	4,954,882	0.001100			90.01
90.02	KEDZIE CLINIC	8,363	2,648,050	0.003158			90.02
90.03	LITTLE VILLAGE CLINIC	4,840	2,343,821	0.002065			90.03
91	EMERGENCY	166,991	38,844,599	0.004299	312,208	1,342	91
92	OBSERVATION BEDS (NON-DISTINC		1,858,608	1,858,608			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,914,975	241,177,150		2,654,085	13,888	200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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	[ ] TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	22,441,544			24,473				50
51	RECOVERY ROOM	1,475,684			1,704				51
52	DELIVERY ROOM & LABOR ROOM	12,748,128							52
53	ANESTHESIOLOGY	9,739,802			10,422				53
54	RADIOLOGY-DIAGNOSTIC	21,625,895			53,505				54
57	CT SCAN	16,989,146			65,464				57
58	MRI	3,363,108			10,266				58
60	LABORATORY	25,887,672			543,747				60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,274,723			25,979				63
65	RESPIRATORY THERAPY	9,767,851			197,760				65
66	PHYSICAL THERAPY	5,606,837			5,799				66
69	ELECTROCARDIOLOGY	6,368,681			97,143				69
70	ELECTROENCEPHALOGRAPHY	851,051			18,612				70
72	IMPL. DEV. CHARGED TO PATIEN	1,277,612							72
73	DRUGS CHARGED TO PATIENTS	42,863,077			1,260,833				73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	2,275,558			340				75
76	HEMODIALYSIS	866,440			25,830				76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,104,381							90
90.01	CHEMOTHERAPY	4,954,882							90.01
90.02	KEDZIE CLINIC	2,648,050							90.02
90.03	LITTLE VILLAGE CLINIC	2,343,821							90.03
91	EMERGENCY	38,844,599			312,208				91
92	OBSERVATION BEDS (NON-DISTIN	1,858,608							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	241,177,150			2,654,085				200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.266048							50
51	RECOVERY ROOM	0.387761							51
52	DELIVERY ROOM & LABOR ROOM	0.497351							52
53	ANESTHESIOLOGY	0.146712							53
54	RADIOLOGY-DIAGNOSTIC	0.245085							54
57	CT SCAN	0.045207							57
58	MRI	0.065132							58
60	LABORATORY	0.187180							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207							63
65	RESPIRATORY THERAPY	0.149203							65
66	PHYSICAL THERAPY	0.285266							66
69	ELECTROCARDIOLOGY	0.148936							69
70	ELECTROENCEPHALOGRAPHY	0.162842							70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557							72
73	DRUGS CHARGED TO PATIENTS	0.162426							73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	0.214042							75
76	HEMODIALYSIS	0.403453							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.839078							90
90.01	CHEMOTHERAPY	0.112555							90.01
90.02	KEDZIE CLINIC	0.417652							90.02
90.03	LITTLE VILLAGE CLINIC	0.261005							90.03
91	EMERGENCY	0.143575							91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773							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 INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	1,491,321		1,491,321	16,527	90.24	11,312	1,020,795	30
31	INTENSIVE CARE UNIT	238,081		238,081	2,664	89.37	806	72,032	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	504,907		504,907	11,275	44.78	5,662	253,544	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	64,129		64,129	3,855	16.64			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	2,298,438		2,298,438	34,321		17,780	1,346,371	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 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	223,625	22,441,544	0.009965			50
51	RECOVERY ROOM	5,897	1,475,684	0.003996			51
52	DELIVERY ROOM & LABOR ROOM	175,984	12,748,128	0.013805			52
53	ANESTHESIOLOGY	32,523	9,739,802	0.003339			53
54	RADIOLOGY-DIAGNOSTIC	393,973	21,625,895	0.018218			54
57	CT SCAN	10,666	16,989,146	0.000628			57
58	MRI	2,559	3,363,108	0.000761			58
60	LABORATORY	239,946	25,887,672	0.009269			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	5,173	3,274,723	0.001580			63
65	RESPIRATORY THERAPY	50,299	9,767,851	0.005149			65
66	PHYSICAL THERAPY	59,193	5,606,837	0.010557			66
69	ELECTROCARDIOLOGY	36,295	6,368,681	0.005699			69
70	ELECTROENCEPHALOGRAPHY	18,534	851,051	0.021778			70
72	IMPL. DEV. CHARGED TO PATIENT	147,523	1,277,612	0.115468			72
73	DRUGS CHARGED TO PATIENTS	137,381	42,863,077	0.003205			73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	4,822	2,275,558	0.002119			75
76	HEMODIALYSIS	2,525	866,440	0.002914			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	182,415	3,104,381	0.058761			90
90.01	CHEMOTHERAPY	5,448	4,954,882	0.001100			90.01
90.02	KEDZIE CLINIC	8,363	2,648,050	0.003158			90.02
90.03	LITTLE VILLAGE CLINIC	4,840	2,343,821	0.002065			90.03
91	EMERGENCY	166,991	38,844,599	0.004299			91
92	OBSERVATION BEDS (NON-DISTINC	108,011	1,858,608	0.058114			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	2,022,986	241,177,150				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	16,527		11,312		30
31	INTENSIVE CARE UNIT	2,664		806		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	11,275		5,662		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	3,855				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	34,321		17,780		200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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	[ ]	TITLE V	[XX]	HOSPITAL (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	22,441,544							50
51	RECOVERY ROOM	1,475,684							51
52	DELIVERY ROOM & LABOR ROOM	12,748,128							52
53	ANESTHESIOLOGY	9,739,802							53
54	RADIOLOGY-DIAGNOSTIC	21,625,895							54
57	CT SCAN	16,989,146							57
58	MRI	3,363,108							58
60	LABORATORY	25,887,672							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,274,723							63
65	RESPIRATORY THERAPY	9,767,851							65
66	PHYSICAL THERAPY	5,606,837							66
69	ELECTROCARDIOLOGY	6,368,681							69
70	ELECTROENCEPHALOGRAPHY	851,051							70
72	IMPL. DEV. CHARGED TO PATIEN	1,277,612							72
73	DRUGS CHARGED TO PATIENTS	42,863,077							73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	2,275,558							75
76	HEMODIALYSIS	866,440							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,104,381							90
90.01	CHEMOTHERAPY	4,954,882							90.01
90.02	KEDZIE CLINIC	2,648,050							90.02
90.03	LITTLE VILLAGE CLINIC	2,343,821							90.03
91	EMERGENCY	38,844,599							91
92	OBSERVATION BEDS (NON-DISTIN	1,858,608							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	241,177,150							200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.266048							50
51	RECOVERY ROOM	0.387761							51
52	DELIVERY ROOM & LABOR ROOM	0.497351							52
53	ANESTHESIOLOGY	0.146712							53
54	RADIOLOGY-DIAGNOSTIC	0.245085							54
57	CT SCAN	0.045207							57
58	MRI	0.065132							58
60	LABORATORY	0.187180							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207							63
65	RESPIRATORY THERAPY	0.149203							65
66	PHYSICAL THERAPY	0.285266							66
69	ELECTROCARDIOLOGY	0.148936							69
70	ELECTROENCEPHALOGRAPHY	0.162842							70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557							72
73	DRUGS CHARGED TO PATIENTS	0.162426							73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	0.214042							75
76	HEMODIALYSIS	0.403453							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.839078							90
90.01	CHEMOTHERAPY	0.112555							90.01
90.02	KEDZIE CLINIC	0.417652							90.02
90.03	LITTLE VILLAGE CLINIC	0.261005							90.03
91	EMERGENCY	0.143575							91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773							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 INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	223,625	22,441,544	0.009965			50
51	RECOVERY ROOM	5,897	1,475,684	0.003996			51
52	DELIVERY ROOM & LABOR ROOM	175,984	12,748,128	0.013805			52
53	ANESTHESIOLOGY	32,523	9,739,802	0.003339			53
54	RADIOLOGY-DIAGNOSTIC	393,973	21,625,895	0.018218			54
57	CT SCAN	10,666	16,989,146	0.000628			57
58	MRI	2,559	3,363,108	0.000761			58
60	LABORATORY	239,946	25,887,672	0.009269			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
63	BLOOD STORING, PROCESSING & T	5,173	3,274,723	0.001580			63
65	RESPIRATORY THERAPY	50,299	9,767,851	0.005149			65
66	PHYSICAL THERAPY	59,193	5,606,837	0.010557			66
69	ELECTROCARDIOLOGY	36,295	6,368,681	0.005699			69
70	ELECTROENCEPHALOGRAPHY	18,534	851,051	0.021778			70
72	IMPL. DEV. CHARGED TO PATIENT	147,523	1,277,612	0.115468			72
73	DRUGS CHARGED TO PATIENTS	137,381	42,863,077	0.003205			73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)	4,822	2,275,558	0.002119			75
76	HEMODIALYSIS	2,525	866,440	0.002914			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	182,415	3,104,381	0.058761			90
90.01	CHEMOTHERAPY	5,448	4,954,882	0.001100			90.01
90.02	KEDZIE CLINIC	8,363	2,648,050	0.003158			90.02
90.03	LITTLE VILLAGE CLINIC	4,840	2,343,821	0.002065			90.03
91	EMERGENCY	166,991	38,844,599	0.004299			91
92	OBSERVATION BEDS (NON-DISTINC		1,858,608	1,858,608			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,914,975	241,177,150				200

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

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

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
63	BLOOD STORING, PROCESSING & T							63
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
75	ASC (NON-DISTINCT PART)							75
76	HEMODIALYSIS							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
90.01	CHEMOTHERAPY							90.01
90.02	KEDZIE CLINIC							90.02
90.03	LITTLE VILLAGE CLINIC							90.03
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	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[ ]	OTHER

	COST CENTER DESCRIPTION	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	22,441,544							50
51	RECOVERY ROOM	1,475,684							51
52	DELIVERY ROOM & LABOR ROOM	12,748,128							52
53	ANESTHESIOLOGY	9,739,802							53
54	RADIOLOGY-DIAGNOSTIC	21,625,895							54
57	CT SCAN	16,989,146							57
58	MRI	3,363,108							58
60	LABORATORY	25,887,672							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
63	BLOOD STORING, PROCESSING &	3,274,723							63
65	RESPIRATORY THERAPY	9,767,851							65
66	PHYSICAL THERAPY	5,606,837							66
69	ELECTROCARDIOLOGY	6,368,681							69
70	ELECTROENCEPHALOGRAPHY	851,051							70
72	IMPL. DEV. CHARGED TO PATIEN	1,277,612							72
73	DRUGS CHARGED TO PATIENTS	42,863,077							73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	2,275,558							75
76	HEMODIALYSIS	866,440							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	3,104,381							90
90.01	CHEMOTHERAPY	4,954,882							90.01
90.02	KEDZIE CLINIC	2,648,050							90.02
90.03	LITTLE VILLAGE CLINIC	2,343,821							90.03
91	EMERGENCY	38,844,599							91
92	OBSERVATION BEDS (NON-DISTIN	1,858,608							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	241,177,150							200

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

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

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES PPS REIMBURSED SERVICES	PROGRAM CHARGES COST REIMB. SERVICES SUBJECT TO DED & COINS	PROGRAM CHARGES COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PROGRAM COSTS PPS SERVICES	PROGRAM COSTS COST SERVICES SUBJECT TO DED & COINS	PROGRAM COSTS COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.266048							50
51	RECOVERY ROOM	0.387761							51
52	DELIVERY ROOM & LABOR ROOM	0.497351							52
53	ANESTHESIOLOGY	0.146712							53
54	RADIOLOGY-DIAGNOSTIC	0.245085							54
57	CT SCAN	0.045207							57
58	MRI	0.065132							58
60	LABORATORY	0.187180							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207							63
65	RESPIRATORY THERAPY	0.149203							65
66	PHYSICAL THERAPY	0.285266							66
69	ELECTROCARDIOLOGY	0.148936							69
70	ELECTROENCEPHALOGRAPHY	0.162842							70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557							72
73	DRUGS CHARGED TO PATIENTS	0.162426							73
74	RENAL DIALYSIS								74
75	ASC (NON-DISTINCT PART)	0.214042							75
76	HEMODIALYSIS	0.403453							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	0.839078							90
90.01	CHEMOTHERAPY	0.112555							90.01
90.02	KEDZIE CLINIC	0.417652							90.02
90.03	LITTLE VILLAGE CLINIC	0.261005							90.03
91	EMERGENCY	0.143575							91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773							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 (14-0095)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	16,527	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	16,527	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,330	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,018	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)	15,006,413	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	15,006,413	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)	15,006,413	37

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

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	907.99	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,648,304	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	3,648,304	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,173,468	2,664	1,566.62	1,854	2,904,513	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)					4,713,995	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					11,266,812	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	528,276	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	203,062	51
52	TOTAL PROGRAM EXCLUDABLE COST	731,338	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	10,535,474	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)	1,197	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	907.99	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	1,086,864	89

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
90	CAPITAL-RELATED COST	1,491,321	15,006,413	0.099379	1,086,864	108,011	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	11,275	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	11,275	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	11,275	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4,110	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,481,707	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,481,707	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)	6,481,707	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	574.87	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,362,716	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	2,362,716	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)	441,036	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	2,803,752	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	184,046	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	13,888	51
52	TOTAL PROGRAM EXCLUDABLE COST	197,934	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	2,605,818	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	16,527	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	16,527	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	15,330	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)	11,312	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	3,855	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)	15,006,413	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	15,006,413	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)	15,006,413	37

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

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	907.99	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	10,271,183	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)	10,271,183	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)	1,521,032	3,855	394.56			42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,173,468	2,664	1,566.62	806	1,262,696	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)					11,533,879	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					1,092,827	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					1,092,827	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					10,441,052	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)	1,197	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)		88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)		89

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

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	11,275	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	11,275	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	11,275	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	5,662	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,481,707	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,481,707	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)	6,481,707	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX] PPS
	[ ]	TITLE XVIII-PT A	[XX]	IPF (14-S095)			[ ] TEFRA
	[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)	574.87	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	3,254,914	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	3,254,914	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)	3,254,914	49
	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	253,544	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST	253,544	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	3,001,370	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (LINE 54 x LINE 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT		57
58	BONUS PAYMENT (SEE INSTRUCTIONS)		58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)		61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)		69

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		9,823,246		30
31	INTENSIVE CARE UNIT		3,691,481		31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.266048	2,413,231	642,035	50
51	RECOVERY ROOM	0.387761	125,275	48,577	51
52	DELIVERY ROOM & LABOR ROOM	0.497351	4,166	2,072	52
53	ANESTHESIOLOGY	0.146712	742,466	108,929	53
54	RADIOLOGY-DIAGNOSTIC	0.245085	1,818,913	445,788	54
57	CT SCAN	0.045207	1,378,643	62,324	57
58	MRI	0.065132	176,894	11,521	58
60	LABORATORY	0.187180	3,603,439	674,492	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207	647,051	125,662	63
65	RESPIRATORY THERAPY	0.149203	3,529,569	526,622	65
66	PHYSICAL THERAPY	0.285266	268,526	76,601	66
69	ELECTROCARDIOLOGY	0.148936	1,144,533	170,462	69
70	ELECTROENCEPHALOGRAPHY	0.162842	81,122	13,210	70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557	411,794	257,189	72
73	DRUGS CHARGED TO PATIENTS	0.162426	6,654,819	1,080,916	73
74	RENAL DIALYSIS				74
75	ASC (NON-DISTINCT PART)	0.214042	25,034	5,358	75
76	HEMODIALYSIS	0.403453	507,822	204,882	76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.839078			90
90.01	CHEMOTHERAPY	0.112555			90.01
90.02	KEDZIE CLINIC	0.417652			90.02
90.03	LITTLE VILLAGE CLINIC	0.261005			90.03
91	EMERGENCY	0.143575	1,792,478	257,355	91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		25,325,775	4,713,995	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		25,325,775		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		6,391,831		40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.266048	24,473	6,511	50
51	RECOVERY ROOM	0.387761	1,704	661	51
52	DELIVERY ROOM & LABOR ROOM	0.497351			52
53	ANESTHESIOLOGY	0.146712	10,422	1,529	53
54	RADIOLOGY-DIAGNOSTIC	0.245085	53,505	13,113	54
57	CT SCAN	0.045207	65,464	2,959	57
58	MRI	0.065132	10,266	669	58
60	LABORATORY	0.187180	543,747	101,779	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207	25,979	5,045	63
65	RESPIRATORY THERAPY	0.149203	197,760	29,506	65
66	PHYSICAL THERAPY	0.285266	5,799	1,654	66
69	ELECTROCARDIOLOGY	0.148936	97,143	14,468	69
70	ELECTROENCEPHALOGRAPHY	0.162842	18,612	3,031	70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557			72
73	DRUGS CHARGED TO PATIENTS	0.162426	1,260,833	204,792	73
74	RENAL DIALYSIS				74
75	ASC (NON-DISTINCT PART)	0.214042	340	73	75
76	HEMODIALYSIS	0.403453	25,830	10,421	76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.839078			90
90.01	CHEMOTHERAPY	0.112555			90.01
90.02	KEDZIE CLINIC	0.417652			90.02
90.03	LITTLE VILLAGE CLINIC	0.261005			90.03
91	EMERGENCY	0.143575	312,208	44,825	91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		2,654,085	441,036	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		2,654,085		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.266048			50
51	RECOVERY ROOM	0.387761			51
52	DELIVERY ROOM & LABOR ROOM	0.497351			52
53	ANESTHESIOLOGY	0.146712			53
54	RADIOLOGY-DIAGNOSTIC	0.245085			54
57	CT SCAN	0.045207			57
58	MRI	0.065132			58
60	LABORATORY	0.187180			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207			63
65	RESPIRATORY THERAPY	0.149203			65
66	PHYSICAL THERAPY	0.285266			66
69	ELECTROCARDIOLOGY	0.148936			69
70	ELECTROENCEPHALOGRAPHY	0.162842			70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557			72
73	DRUGS CHARGED TO PATIENTS	0.162426			73
74	RENAL DIALYSIS				74
75	ASC (NON-DISTINCT PART)	0.214042			75
76	HEMODIALYSIS	0.403453			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.839078			90
90.01	CHEMOTHERAPY	0.112555			90.01
90.02	KEDZIE CLINIC	0.417652			90.02
90.03	LITTLE VILLAGE CLINIC	0.261005			90.03
91	EMERGENCY	0.143575			91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773			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

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

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

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.266048			50
51	RECOVERY ROOM	0.387761			51
52	DELIVERY ROOM & LABOR ROOM	0.497351			52
53	ANESTHESIOLOGY	0.146712			53
54	RADIOLOGY-DIAGNOSTIC	0.245085			54
57	CT SCAN	0.045207			57
58	MRI	0.065132			58
60	LABORATORY	0.187180			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRA	0.194207			63
65	RESPIRATORY THERAPY	0.149203			65
66	PHYSICAL THERAPY	0.285266			66
69	ELECTROCARDIOLOGY	0.148936			69
70	ELECTROENCEPHALOGRAPHY	0.162842			70
72	IMPL. DEV. CHARGED TO PATIENTS	0.624557			72
73	DRUGS CHARGED TO PATIENTS	0.162426			73
74	RENAL DIALYSIS				74
75	ASC (NON-DISTINCT PART)	0.214042			75
76	HEMODIALYSIS	0.403453			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	0.839078			90
90.01	CHEMOTHERAPY	0.112555			90.01
90.02	KEDZIE CLINIC	0.417652			90.02
90.03	LITTLE VILLAGE CLINIC	0.261005			90.03
91	EMERGENCY	0.143575			91
92	OBSERVATION BEDS (NON-DISTINCT	0.584773			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 (14-0095)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,882,958	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	116,894	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	242,576	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	105.72	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)	5.59	5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)	5.59	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	2.02	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	2.02	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	1.78	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	1.78	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	1.86	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	1.86	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.017594	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.016353	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.016353	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	72,301	22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)	-3.57	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)	72,301	29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.1614	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)	0.5693	31
32	SUM OF LINES 30 AND 31	0.7307	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.4950	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,902,064	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)	11,974,217	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	11,974,217	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	746,571	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 (14-0095)
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)	57,403	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)	12,778,191	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	12,778,191	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	811,504	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	102,158	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	748,048	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	523,634	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	748,048	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	12,388,163	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)	-5,896	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-23,879	70.94
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	12,358,388	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	61,792	71.01
72	INTERIM PAYMENTS	12,199,544	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	97,052	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	331,873	75

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,377	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	5,409,811	2
3	PPS PAYMENTS	5,524,721	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	23,633	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	5,377	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	33,102	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)	33,102	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)	33,102	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	27,725	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)	5,377	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)	5,548,354	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,225,649	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	4,328,082	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)	22,091	28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	4,350,173	30
31	PRIMARY PAYER PAYMENTS	179	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	4,349,994	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)	680,396	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	476,277	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	680,396	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	4,826,271	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	4,826,271	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	24,131	40.01
41	INTERIM PAYMENTS	4,712,644	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	89,496	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)		2
3	PPS PAYMENTS		3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)		5
6	LINE 2 TIMES LINE 5		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)		14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)		19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS)		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)		21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)		24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)		26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)		30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)		32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)		40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		40.01
41	INTERIM PAYMENTS		41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)		43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

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

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

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				11,987,547		4,583,518	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	05/09/2013	211,997	05/09/2013	129,126	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		211,997		129,126	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)				12,199,544		4,712,644	4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		158,844		113,627	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				12,358,388		4,826,271	7

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

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

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

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,808,406			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				2,808,406			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.		.01					5.01
	PROGRAM TO PROVIDER	.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.50		NONE		NONE	5.50
		.51					5.51
	PROVIDER TO 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		12,913			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				2,821,319			7

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

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

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	7,279	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	5,872	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	206	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	17,994	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	301,388,100	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	21,818,740	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
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)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART II

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (EXCLUDING OUTLIER, ECT, AND MEDICAL EDUCATION PAYMENTS	3,275,647	1
2	NET IPF PPS OUTLIER PAYMENT	3,476	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004 (SEE INSTRUCTIONS)		4
4.01	CAP INCREASES FOR THE UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR RESIDENTS THAT WERE DISPLACED BY PROGRAM OR HOSPITAL CLOSURE, THAT WOULD NOT BE COUNTED WITHOUT A TEMPORARY CAP ADJUSTMENT UNDER §412.424(d)(1)(iii)(F)(1) OR (2) (SEE INSTRUCTIONS)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTRUCTIONS)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM' (SEE INSTRUCTIONS)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)		8
9	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	30.890411	9
10	TEACHING ADJUSTMENT FACTOR {((1 + (LINE 8/LINE 9)) RAISED TO THE POWER OF .5150 -1}		10
11	TEACHING ADJUSTMENT (LINE 1 MULTIPLIED BY LINE 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1, 2, 3 AND 11)	3,279,123	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		15
16	SUBTOTAL (SEE INSTRUCTIONS)	3,279,123	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (LINE 16 LESS LINE 17)	3,279,123	18
19	DEDUCTIBLES	188,384	19
20	SUBTOTAL (LINE 18 MINUS LINE 19)	3,090,739	20
21	COINSURANCE	269,420	21
22	SUBTOTAL (LINE 20 MINUS LINE 21)	2,821,319	22
23	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		25
26	SUBTOTAL (SUM OF LINES 22 AND 24)	2,821,319	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49) (FOR FREESTANDING IPF ONLY)		27
28	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)		28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	2,821,319	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	14,107	31.01
32	INTERIM PAYMENTS	2,808,406	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)	-1,194	34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

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

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

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

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			5.59	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3.26	3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)				3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))				4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011				4.02
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 AND 4.02 PLUS APPLICABLE SUBSCRIPTS)			2.33	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			2.02	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			2.02	7
		PRIMARY CARE 1	OTHER 2	TOTAL 3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	0.95	1.07	2.02	8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6	0.95	1.07	2.02	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT	0.95	1.07		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	1.23	0.55		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	1.22	0.05		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	1.13	0.56		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	1.13	0.56		17
18	PER RESIDENT AMOUNT	138,208.51	130,103.67		18
19	APPROVED AMOUNT FOR RESIDENT COSTS	156,176	72,858	229,034	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			229,034	25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	9,982	206		26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	29,269	29,269		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.341043	0.007038		28
29	PROGRAM DIRECT GME AMOUNT	78,110	1,612		29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		228		30
31	NET PROGRAM DIRECT GME AMOUNT			79,494	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)				33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)				34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)				35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			14,070,564	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)				38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)				39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			14,070,564	41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			5,415,188	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			179	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			5,415,009	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			19,485,573	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.722102	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.277898	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			79,494	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			57,403	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			22,091	50

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

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT

1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996	1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)	2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA	3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH 42 CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)	3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))	4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011	4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011	4.02
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 AND 4.02 PLUS APPLICABLE SUBSCRIPTS)	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6	7

		PRIMARY CARE 1	OTHER 2	TOTAL 3	
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR				8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6				9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR				10
11	TOTAL WEIGHTED FTE COUNT				11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)				12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)				13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)				14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS				15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT				17
18	PER RESIDENT AMOUNT				18
19	APPROVED AMOUNT FOR RESIDENT COSTS				19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)				21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)				22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)				23
24	MULTIPLY LINE 22 TIMES LINE 23				24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)				25

COMPUTATION OF PROGRAM PATIENT LOAD

		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	17,780		26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	29,269		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.607469		28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			30
31	NET PROGRAM DIRECT GME AMOUNT			31

DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)

32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)	32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)	33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)	34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)	35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)	36

APPORTIONMENT OF MEDICARE REASONABLE COST OF GME

PART A REASONABLE COST

37	REASONABLE COST (SEE INSTRUCTIONS)	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)	38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)	39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)	41

PART B REASONABLE COST

42	REASONABLE COST (SEE INSTRUCTIONS)	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)	43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)	47

ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B

48	TOTAL PROGRAM GME PAYMENT (LINE 31)	48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)	50

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	10,994,734				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	11,492,122				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	1,739,179				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	2,177,746				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	26,403,781				11
	FIXED ASSETS					
12	LAND	973,787				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	63,755,321				15
16	ACCUMULATED DEPRECIATION	-38,578,030				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT					23
24	ACCUMULATED DEPRECIATION					24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	26,151,078				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	29,429,908				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	29,429,908				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	81,984,767				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	5,827,465				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	-264,821				43
44	OTHER CURRENT LIABILITIES	12,953,117				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	18,515,761				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	775,392				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	775,392				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	19,291,153				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	62,693,614				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)	62,693,614				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	81,984,767				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1 2	3 4	5 6	7 8	
1	FUND BALANCES AT BEGINNING OF PERIOD	63,211,359				1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	298,892				2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	63,510,251				3
4	ADDITIONS (CREDIT ADJUST-MENTS)					4
5	UNRESTRICTED ASSETS					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)					10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	63,510,251				11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)					12
13	UNRESTRICTED ASSETS	816,637				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)	816,637				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	62,693,614				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	28,013,724		28,013,724	1
2	SUBPROVIDER IPF	17,596,825		17,596,825	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)	45,610,549		45,610,549	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	8,896,131		8,896,131	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)	8,896,131		8,896,131	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	54,506,680		54,506,680	17
18	ANCILLARY SERVICES	99,831,278	146,554,676	246,385,954	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES		18,950	18,950	27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	154,337,958	146,573,626	300,911,584	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		97,021,472	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38	PHYSICIAN PRACTICE REVENUE	-18,682,782		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-18,682,782	42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		78,338,690	43

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	300,911,584	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	229,771,309	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	71,140,275	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	78,338,690	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-7,198,415	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 (OTHER OPERATING REVENUE)	7,567,943	24
24.01	OTHER (PHYSICIAN REVENUE)		24.01
24.02	OTHER (RECONCILING ITEM)		24.02
24.03	OTHER (RENTAL INCOME FROM OUTSIDE CLINICS)		24.03
24.04	OTHER (STUDENT MENTORING PROGRAM)		24.04
24.05	OTHER (HOUSE STAFF/PEDS& MED STUDENT PROGR)		24.05
24.06	OTHER (FINANCIAL CENTER ,ADMINISTRATION &)		24.06
24.07	OTHER (ADMINISTRATION FHN CONTRIBUTION)		24.07
24.08	OTHER (FINANCE DEPT.)		24.08
24.09	OTHER (FQHC CLINIC SOUTH LAWNDALE)		24.09
24.10	OTHER (FQHC CLINIC LOWER WESTSIDE)		24.10
24.11	OTHER (MIDWIFERY CITY OF CHGO GRANT)		24.11
24.12	OTHER (SURGERY CAPITAL GRANT)		24.12
24.13	OTHER (QUALITY ASSURANCE)		24.13
24.14	OTHER (PROGRAM CIELO)		24.14
24.15	OTHER (51ST STREET CLINIC GRANT)		24.15
24.16	OTHER (59 TH STREET CLINIC GRANT)		24.16
24.17	OTHER (VENDING MACHINES COMMISIONS)		24.17
24.18	OTHER (LAB ADMINISTRATION)		24.18
24.19	OTHER (RADIOLOGY)		24.19
24.20	OTHER (EMERGENCY DEPARTMENT)		24.20
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	7,567,943	25
26	TOTAL (LINE 5 PLUS LINE 25)	369,528	26
27	OTHER EXPENSES (NON-OPERATING INCOME)	70,636	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	70,636	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	298,892	29

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	629,606	1
2	CAPITAL DRG OUTLIER PAYMENTS	9,806	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	49.30	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	1.86	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0107	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6,737	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.1614	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (SEE INSTRUCTIONS)	0.5693	8
9	SUM OF LINES 7 AND 8	0.7307	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1595	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	100,422	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	746,571	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 ((14-009)	[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	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	PURCHASING, RECEIVING						5.02
5.03	ADMITTING						5.03
5.04	CASHERING/ACCOUNTS RECEIVABLE						5.04
5.05	DATA PROCESSING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R 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
40	SUBPROVIDER - IPF						40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
51	RECOVERY ROOM						51
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
63	BLOOD STORING, PROCESSING & TR						63
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
75	ASC (NON-DISTINCT PART)						75
76	HEMODIALYSIS						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
90.01	CHEMOTHERAPY						90.01
90.02	KEDZIE CLINIC						90.02
90.03	LITTLE VILLAGE CLINIC						90.03
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAP						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	FUND DEVELOPMENT						192.01

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

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

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