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: 01-30-2014 TIME: 09:55_____
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 NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 09/01/2012 AND ENDING 08/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XVIII HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		109,544	147,340	-47,322		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		109,544	147,340	-47,322		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: 660 WESTMORELAND ROAD P.O.BOX: 1
2 CITY: LAKE FOREST STATE: IL ZIP CODE: 60045 COUNTY: LAKE 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	NORTHWESTERN LAKE FOREST HOSPI	14-0130	29404	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	NORTHWESTERN LAKE FOREST HOSPI	14-5216	29404		07/01/1970	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	NORTHWESTERN LAKE FOREST HOME	14-7045	29404		07/01/1966	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 09/01/2012		TO: 08/31/2013						20
21	TYPE OF CONTROL			2						21

INPATIENT PPS INFORMATION

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

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

		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 1	XVIII 2	XIX 3	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL					
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

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

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	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.	Y	Y		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 FTEs, AND PRIMARY CARE FTEs ADDED UNDER 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 1	PROGRAM CODE 2	UNWEIGHTED IME FTE COUNT 3	UNWEIGHTED DIRECT GME FTE COUNT 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)		0.87		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)		0.87		66

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	70
71	IF LINE 70 YES:		71

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

INPATIENT REHABILITATION FACILITY PPS

75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	75
76	IF LINE 75 YES:		76

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

LONG TERM CARE HOSPITAL PPS

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

TEFRA PROVIDERS

85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.	N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	86

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
RURAL PROVIDERS			1	2	
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?		N		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.				106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.				107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.		N		108
		PHY-SICAL	OCCUP-ATIONAL	SPEECH	RESPI-RATORY	
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.	N				109
MISCELLANEOUS COST REPORTING INFORMATION						
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N				115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.			Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 675,227 PAID LOSSES: 1,481,006 SELF INSURANCE: 62,574					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.	Y	HB0640	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: NORTHWESTERN MEMORIAL HEALTHCA	CONTRACTOR'S NAME: NGS	CONTRACTOR'S NUMBER: HB0640	141
142	STREET: 251 E HURON ST	P.O. BOX:		142
143	CITY: CHICAGO	STATE: IL	ZIP CODE: 60611	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		Y	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

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

MULTICAMPUS

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

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.		Y	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		0.75	169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)	10/01/2012	09/30/2013	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	DATE		
	PROVIDER ORGANIZATION AND OPERATION	1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			1

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

		Y/N	TYPE	DATE	
	FINANCIAL DATA AND REPORTS	1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	11/18/2011	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5

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

		Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.	N	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.		13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		14

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
	PS&R REPORT DATA	1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		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	11/15/2012	Y	11/15/2012	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: JOHN LAST NAME: VANDER LAAN TITLE: MANAGER 41

42 EMPLOYER: NORTHWESTERN MEMORIAL HEALTHCA 42

43 PHONE NUMBER: (312) 926-6618 E-MAIL ADDRESS: JVANDERL@NMH.ORG 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	107	39,055			8,690	1,142	21,369	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						331	242		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.)		107	39,055			8,690	1,142	21,369	7
8	INTENSIVE CARE UNIT	31	10	3,650			1,002	200	2,213	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						430	1,230	13
14	TOTAL (SEE INSTRUCTIONS)		117	42,705			9,692	1,772	24,812	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	30	10,950			7,218		9,055	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101							8,050	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)		147							27
28	OBSERVATION BED DAYS								2,680	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								393	30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)							44	701	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					2,591	656	7,947	1
2	HMO AND OTHER (SEE INSTRUCTIONS)						89			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)		0.87	1,300.76			2,591	656	7,947	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		0.87	1,300.76						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	87,753,523	732,937	88,486,460	2,636,384.00	33.56	1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE		1,064,010		1,064,010	7,316.00	145.44	4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B		6,292,021		6,292,021	38,486.00	163.49	5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21		50,261	50,261	1,802.00	27.89	7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44	2,561,440		2,561,440	88,166.79	29.05	9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		10,528,813	-2,854,320	7,674,493	256,840.00	29.88	10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		43,854		43,854	707.00	62.03	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		12,128,209		12,128,209	189,534.00	63.99	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)		15,558,825		15,558,825			17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		2,025,774		2,025,774			19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B		569,710		569,710			23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		1,046	1,876	2,922	90.00	32.47	26
27	ADMINISTRATIVE & GENERAL		14,427,250	803,548	15,230,798	431,342.00	35.31	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		2,431,170		2,431,170	97,897.00	24.83	30
31	LAUNDRY & LINEN SERVICE		271,333		271,333	19,663.00	13.80	31
32	HOUSEKEEPING		1,382,421	-19,211	1,363,210	99,090.00	13.76	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		7,361	-2,247	5,114	124.00	41.24	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA			1,018	1,018	25.00	40.72	36
37	MAINTENANCE OF PERSONNEL		20,342	335	20,677	874.00	23.66	37
38	NURSING ADMINISTRATION		2,359,292		2,359,292	52,972.00	44.54	38
39	CENTRAL SERVICES AND SUPPLY		647,026		647,026	40,027.00	16.16	39
40	PHARMACY		1,515,350		1,515,350	38,430.00	39.43	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		605,940		605,940	27,270.25	22.22	41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	81,461,502	682,676	82,144,178	2,596,096.00	31.64	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	13,090,253	-2,854,320	10,235,933	345,006.79	29.67	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	68,371,249	3,536,996	71,908,245	2,251,089.21	31.94	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	12,172,063		12,172,063	190,241.00	63.98	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	15,558,825		15,558,825		21.64%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	96,102,137	3,536,996	99,639,133	2,441,330.21	40.81	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	23,668,531	785,319	24,453,850	807,804.25	30.27	7

HOSPITAL WAGE RELATED COSTS WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	3,465,284	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	50,000	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)	4,110,212	8
9	PRESCRIPTION DRUG PLAN	1,604,901	9
10	DENTAL, HEARING AND VISION PLAN	242,916	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	59,610	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	834,179	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	677,444	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	6,506,759	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	380,289	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	222,714	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	18,154,308	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA HHA NO.: 14-7045 WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA COUNTY: LAKE

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

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

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

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

HOME HEALTH AGENCY CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	2	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).	16974	20
20.01		29404	20.01

PPS ACTIVITY

		FULL EPISODES WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	TOTAL (COLS. 1-4) 5	
21	SKILLED NURSING VISITS	3,840	317	105	96	4,358	21
22	SKILLED NURSING VISIT CHARGES	1,196,843	98,910	34,004	30,110	1,359,867	22
23	PHYSICAL THERAPY VISITS	2,685	74	10	73	2,842	23
24	PHYSICAL THERAPY VISIT CHARGES	857,865	23,569	3,515	23,565	908,514	24
25	OCCUPATIONAL THERAPY VISITS	85	1			86	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	28,215	355			28,570	26
27	SPEECH PATHOLOGY VISITS	35				35	27
28	SPEECH PATHOLOGY VISIT CHARGES	11,234				11,234	28
29	MEDICAL SOCIAL SERVICE VISITS	95	19	1	2	117	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	41,745	8,493	447	894	51,579	30
31	HOME HEALTH AIDE VISITS	547	59		6	612	31
32	HOME HEALTH AIDE VISIT CHARGES	101,852	11,219		1,146	114,217	32
33	TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	7,287	470	116	177	8,050	33
34	OTHER CHARGES	28,143	2,152	3,437	3,944	37,676	34
35	TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	2,265,897	144,698	41,403	59,659	2,511,657	35
36	TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	440		38	15	493	36
37	TOTAL NUMBER OF OUTLIER EPISODES		12			12	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES						38

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

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

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	860		860	12
13	RUB	2,738		2,738	13
14	RUA	880		880	14
15	RVC	766		766	15
16	RVB	1,030		1,030	16
17	RVA	239		239	17
18	RHC	204		204	18
19	RHB	164		164	19
20	RHA	26		26	20
21	RMC	93		93	21
22	RMB	70		70	22
23	RMA	16		16	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2	56		56	29
30	HE1	11		11	30
31	HD2				31
32	HD1	1		1	32
33	HC2	22		22	33
34	HC1	10		10	34
35	HB2				35
36	HB1	6		6	36
37	LE2	6		6	37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	7		7	48
49	CC2				49
50	CC1	5		5	50
51	CB2				51
52	CB1	2		2	52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4	
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1	1		1	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1	5		5	78
199	AAA				199
200	TOTAL	7,218		7,218	200

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

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

		EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING			Y	202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING			Y	205
206	OTHER (OTHER (STAFF MEETINGS))			Y	206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	9,055,000			207

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)	0.265525	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	1,797,529	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	50,586,585	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	13,432,003	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.	11,634,474	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)	11,634,474	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	30,115,298	2,461,770	32,577,068	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	7,996,365	653,661	8,650,026	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	56,841	107,751	164,592	22
23	COST OF CHARITY CARE	7,939,524	545,910	8,485,434	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)	7,329,791	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	247,903	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	7,081,888	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	1,880,418	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	10,365,852	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	22,000,326	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		12,943,252	12,943,252	-3,335,128	1
2	00200	CAP REL COSTS-MVBLE EQUIP		8,325,093	8,325,093	4,970,832	2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,046	14,395,803	14,396,849	68,028	4
5	00500	ADMINISTRATIVE & GENERAL	14,427,250	47,943,512	62,370,762	-1,557,132	5
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	2,431,170	6,889,560	9,320,730		7
8	00800	LAUNDRY & LINEN SERVICE	271,333	193,066	464,399		8
9	00900	HOUSEKEEPING	1,382,421	1,148,066	2,530,487	-19,211	9
10	01000	DIETARY	7,361	4,250,245	4,257,606	-1,406,071	10
11	01100	CAFETERIA		650,138	650,138	636,969	11
12	01200	MAINTENANCE OF PERSONNEL	20,342	347,282	367,624	12,157	12
13	01300	NURSING ADMINISTRATION	2,359,292	451,535	2,810,827	34,263	13
14	01400	CENTRAL SERVICES & SUPPLY	647,026	131,747	778,773	-13,801	14
15	01500	PHARMACY	1,515,350	8,378,920	9,894,270	-8,011,334	15
16	01600	MEDICAL RECORDS & LIBRARY	605,940	106,310	712,250		16
17	01700	SOCIAL SERVICE					17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				50,261	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				14,000	22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	10,816,875	920,590	11,737,465	-967,357	30
31	03100	INTENSIVE CARE UNIT	1,772,981	306,316	2,079,297	59,111	31
43	04300	NURSERY	729,375	70,696	800,071	1,015,716	43
44	04400	SKILLED NURSING FACILITY	2,561,440	226,359	2,787,799		44
45	04500	NURSING FACILITY	1,402,831	472,650	1,875,481	788,313	45
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	7,560,271	14,319,796	21,880,067	-12,226,040	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,421,890	452,826	2,874,716	-31,456	52
54	05400	RADIOLOGY-DIAGNOSTIC	5,956,122	3,870,062	9,826,184	-181,482	54
55	05500	RADIOLOGY-THERAPEUTIC	749,757	324,520	1,074,277		55
57	05700	CT SCAN	625,057	556,501	1,181,558	-85,407	57
58	05800	MRI	1,570,615	338,080	1,908,695	-158,058	58
59	05900	CARDIAC CATHETERIZATION	611,683	1,315,587	1,927,270	-1,128,928	59
60	06000	LABORATORY	2,988,051	4,726,479	7,714,530	65,713	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	854,151	191,818	1,045,969	-44,309	65
66	06600	PHYSICAL THERAPY	3,244,000	59,641	3,303,641	62,802	66
68	06800	SPEECH PATHOLOGY	908,315	300,160	1,208,475	52,217	68
69	06900	ELECTROCARDIOLOGY	593,340	43,246	636,586		69
70	07000	ELECTROENCEPHALOGRAPHY	205,919	12,505	218,424		70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				6,900,328	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				6,719,135	72
73	07300	DRUGS CHARGED TO PATIENTS				8,465,155	73
74	07400	RENAL DIALYSIS					74
76.97	07697	CARDIAC REHABILITATION	420,799	29,694	450,493		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	477,585	62,387	539,972	-94	90.01
90.02	09002	WOUND CLINIC	307,961	543,526	851,487	-12,060	90.02
91	09100	EMERGENCY	8,179,992	1,376,978	9,556,970	2,723,974	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
92.01	09201	OBSERVATION BEDS-DISTINCT		6,563	6,563		92.01
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
101	10100	HOME HEALTH AGENCY	2,494,444	936,497	3,430,941	32,772	101
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	81,121,985	137,618,006	218,739,991	3,493,878	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	401,291	739,771	1,141,062		190
192	19200	PHYSICIANS' PRIVATE OFFICES	2,920,056	3,087,184	6,007,240	-3,493,878	192
194	07950	HEALTH & FITNESS CENTER	3,340,467	3,833,787	7,174,254		194
194.01	07951	OCCUPATIONAL HEALTH	-30,276	74,208	43,932		194.01
200		TOTAL (SUM OF LINES 118-199)	87,753,523	145,352,956	233,106,479		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	9,608,124		9,608,124	1
2	00200	CAP REL COSTS-MVBLE EQUIP	13,295,925	-7,115,984	6,179,941	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	14,464,877	-34,138	14,430,739	4
5	00500	ADMINISTRATIVE & GENERAL	60,813,630	-5,300,893	55,512,737	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	9,320,730	-1,591	9,319,139	7
8	00800	LAUNDRY & LINEN SERVICE	464,399	-301	464,098	8
9	00900	HOUSEKEEPING	2,511,276	-3	2,511,273	9
10	01000	DIETARY	2,851,535	-810,583	2,040,952	10
11	01100	CAFETERIA	1,287,107	-311,436	975,671	11
12	01200	MAINTENANCE OF PERSONNEL	379,781	-69,519	310,262	12
13	01300	NURSING ADMINISTRATION	2,845,090		2,845,090	13
14	01400	CENTRAL SERVICES & SUPPLY	764,972	-206	764,766	14
15	01500	PHARMACY	1,882,936	748	1,883,684	15
16	01600	MEDICAL RECORDS & LIBRARY	712,250	3,714	715,964	16
17	01700	SOCIAL SERVICE				17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	50,261		50,261	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	14,000		14,000	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	10,770,108	-2,076	10,768,032	30
31	03100	INTENSIVE CARE UNIT	2,138,408		2,138,408	31
43	04300	NURSERY	1,815,787		1,815,787	43
44	04400	SKILLED NURSING FACILITY	2,787,799		2,787,799	44
45	04500	NURSING FACILITY	2,663,794	-132,289	2,531,505	45
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	9,654,027	-43,680	9,610,347	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,843,260	-65,945	2,777,315	52
54	05400	RADIOLOGY-DIAGNOSTIC	9,644,702	-83,683	9,561,019	54
55	05500	RADIOLOGY-THERAPEUTIC	1,074,277	-475	1,073,802	55
57	05700	CT SCAN	1,096,151		1,096,151	57
58	05800	MRI	1,750,637	-15	1,750,622	58
59	05900	CARDIAC CATHETERIZATION	798,342		798,342	59
60	06000	LABORATORY	7,780,243	-23,935	7,756,308	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	1,001,660		1,001,660	65
66	06600	PHYSICAL THERAPY	3,366,443	-14,335	3,352,108	66
68	06800	SPEECH PATHOLOGY	1,260,692	-7,024	1,253,668	68
69	06900	ELECTROCARDIOLOGY	636,586	-22,927	613,659	69
70	07000	ELECTROENCEPHALOGRAPHY	218,424		218,424	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,900,328		6,900,328	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	6,719,135		6,719,135	72
73	07300	DRUGS CHARGED TO PATIENTS	8,465,155		8,465,155	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION	450,493	-8,004	442,489	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	539,878		539,878	90.01
90.02	09002	WOUND CLINIC	839,427	-17,851	821,576	90.02
91	09100	EMERGENCY	12,280,944	-6,644,549	5,636,395	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
92.01	09201	OBSERVATION BEDS-DISTINCT	6,563		6,563	92.01
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
101	10100	HOME HEALTH AGENCY	3,463,713	-1,509,656	1,954,057	101
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	222,233,869	-22,216,636	200,017,233	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,141,062	-1,141,062		190
192	19200	PHYSICIANS' PRIVATE OFFICES	2,513,362	-2,513,362		192
194	07950	HEALTH & FITNESS CENTER	7,174,254	-7,174,254		194
194.01	07951	OCCUPATIONAL HEALTH	43,932	-119	43,813	194.01
200		TOTAL (SUM OF LINES 118-199)	233,106,479	-33,045,433	200,061,046	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	IMPLANT RECLASS	A	IMPL. DEV. CHARGED TO PATIENT	72		6,719,135	1
2	IMPLANT RECLASS	A					2
3	IMPLANT RECLASS	A					3
500	TOTAL RECLASSIFICATIONS					6,719,135	500
	CODE LETTER - A						
1	MED SUPPLY	B	MEDICAL SUPPLIES CHARGED TO P	71		6,900,328	1
2	MED SUPPLY	B					2
3	MED SUPPLY	B					3
4	MED SUPPLY	B					4
5	MED SUPPLY	B					5
6	MED SUPPLY	B					6
7	MED SUPPLY	B					7
8	MED SUPPLY	B					8
9	MED SUPPLY	B					9
10	MED SUPPLY	B					10
11	MED SUPPLY	B					11
12	MED SUPPLY	B					12
13	MED SUPPLY	B					13
14	MED SUPPLY	B					14
15	MED SUPPLY	B					15
500	TOTAL RECLASSIFICATIONS					6,900,328	500
	CODE LETTER - B						
1	DRUG RECLASS	C	DRUGS CHARGED TO PATIENTS	73		8,465,155	1
2	DRUG RECLASS	C					2
3	DRUG RECLASS	C					3
4	DRUG RECLASS	C					4
5	DRUG RECLASS	C					5
6	DRUG RECLASS	C					6
7	DRUG RECLASS	C					7
8	DRUG RECLASS	C					8
9	DRUG RECLASS	C					9
500	TOTAL RECLASSIFICATIONS					8,465,155	500
	CODE LETTER - C						
1	HOUSEKEEPING	D	NURSING FACILITY	45	19,211		1
500	TOTAL RECLASSIFICATIONS				19,211		500
	CODE LETTER - D						
1	CAPITAL RELATED RECLASS	E	NURSING ADMINISTRATION	13		34,263	1
2			ADULTS & PEDIATRICS	30		55,433	2
3	HOME OFFICE DEPRECIATION EXPENSE	E	CAP REL COSTS-MVBLE EQUIP	2		1,635,704	3
4	BUILDING DEPRECIATE RECLASS TO EQUI	E	CAP REL COSTS-MVBLE EQUIP	2		3,335,128	4
500	TOTAL RECLASSIFICATIONS					5,060,528	500
	CODE LETTER - E						
1	MOB	G	ADMINISTRATIVE & GENERAL	5	5,466	162,802	1
2	MOB	G	MAINTENANCE OF PERSONNEL	12	335	11,822	2
3	MOB	G	RADIOLOGY-DIAGNOSTIC	54	2,012	63,242	3
4	MOB	G	LABORATORY	60	2,427	65,340	4
5	MOB	G	PHYSICAL THERAPY	66	2,638	60,175	5
6	MOB	G	SPEECH PATHOLOGY	68	4,194	85,610	6
7	MOB	G	ADULTS & PEDIATRICS	30	27	2,440	7
8	MOB	G	WOUND CLINIC	90.02	722	16,476	8
9	MOB	G	CARDIAC CATHETERIZATION	59	239	21,717	9
10	MOB	G	HOME HEALTH AGENCY	101	1,031	31,741	10
11	MOB	G	EMPLOYEE BENEFITS DEPARTMENT	4	1,876	66,152	11
12			INTENSIVE CARE UNIT	31	2,160	57,326	12
500	TOTAL RECLASSIFICATIONS				23,127	644,843	500
	CODE LETTER - G						
1	NURSERY RECLASS	H	NURSERY	43	928,324	88,269	1
500	TOTAL RECLASSIFICATIONS				928,324	88,269	500
	CODE LETTER - H						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	MED ED RECLASS	I	I&R SERVICES-SALARY & FRINGES	21	50,261		1
2			I&R SERVICES-OTHER PRGM COSTS	22		6,500	2
3			I&R SERVICES-OTHER PRGM COSTS	22		7,500	3
500	TOTAL RECLASSIFICATIONS				50,261	14,000	500
	CODE LETTER - I						
1	DIETARY RECLASS	J	CAFETERIA	11	1,018	635,951	1
2			NURSING FACILITY	45	1,229	767,873	2
500	TOTAL RECLASSIFICATIONS				2,247	1,403,824	500
	CODE LETTER - J						
1	ACCT 615200 RECL SALARY TO NON	K	ADMINISTRATIVE & GENERAL	5	1,500		1
2	ACCT 615200 RECL SALARY TO NON	K	RADIOLOGY-DIAGNOSTIC	54		37,400	2
3	ACCT 615200 RECL SALARY TO NON	K	RADIOLOGY-THERAPEUTIC	55	3,795		3
4	ACCT 615200 RECL SALARY TO NON	K	EMERGENCY	91		700	4
5	ACCT 615200 RECL SALARY TO NON	K	HOME HEALTH AGENCY	101		76,079	5
6	ACCT 744000 RECL CC 3016 NON TO SAL	K	ADMINISTRATIVE & GENERAL	5	741,038		6
7	ACCT 744000 RECL CC 3340 NON TO SAL	K	ADMINISTRATIVE & GENERAL	5	55,544		7
8	ACCT 744000 RECL CC 3260 NON TO SAL	K	WOUND CLINIC	90.02	45,239		8
9	RECLASS TO EMERGENCY LINE	K	EMERGENCY	91	2,776,585	49,323	9
500	TOTAL RECLASSIFICATIONS				3,623,701	163,502	500
	CODE LETTER - K						
	GRAND TOTAL (INCREASES)				4,646,871	29,459,584	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER		WKST A-7 REF.
	1		6	7	8	9		10
1	IMPLANT RECLASS	A	OPERATING ROOM	50		6,087,396		1
2	IMPLANT RECLASS	A	RADIOLOGY-DIAGNOSTIC	54		32,192		2
3	IMPLANT RECLASS	A	CARDIAC CATHETERIZATION	59		599,547		3
500	TOTAL RECLASSIFICATIONS					6,719,135		500
	CODE LETTER - A							
1	MED SUPPLY	B	CENTRAL SERVICES & SUPPLY	14		13,801		1
2	MED SUPPLY	B	ADULTS & PEDIATRICS	30		8,664		2
3	MED SUPPLY	B	INTENSIVE CARE UNIT	31		375		3
4	MED SUPPLY	B	NURSERY	43		877		4
5	MED SUPPLY	B	OPERATING ROOM	50		6,046,019		5
6	MED SUPPLY	B	DELIVERY ROOM & LABOR ROOM	52		31,456		6
7	MED SUPPLY	B	RADIOLOGY-DIAGNOSTIC	54		173,296		7
8	MED SUPPLY	B	CT SCAN	57		1,385		8
9	MED SUPPLY	B	MRI	58		30		9
10	MED SUPPLY	B	CARDIAC CATHETERIZATION	59		525,037		10
11	MED SUPPLY	B	RESPIRATORY THERAPY	65		44,309		11
12	MED SUPPLY	B	PHYSICAL THERAPY	66		11		12
13	MED SUPPLY	B	SPEECH PATHOLOGY	68		37,587		13
14	MED SUPPLY	B	OP PEDS ONC CLINIC	90.01		94		14
15	MED SUPPLY	B	EMERGENCY	91		17,387		15
500	TOTAL RECLASSIFICATIONS					6,900,328		500
	CODE LETTER - B							
1	DRUG RECLASS	C	PHARMACY	15		8,011,334		1
2	DRUG RECLASS	C	OPERATING ROOM	50		92,625		2
3	DRUG RECLASS	C	RADIOLOGY-DIAGNOSTIC	54		41,248		3
4	DRUG RECLASS	C	CT SCAN	57		84,022		4
5	DRUG RECLASS	C	MRI	58		158,028		5
6	DRUG RECLASS	C	CARDIAC CATHETERIZATION	59		26,300		6
7	DRUG RECLASS	C	LABORATORY	60		2,054		7
8	DRUG RECLASS	C	WOUND CLINIC	90.02		29,258		8
9	DRUG RECLASS	C	EMERGENCY	91		20,286		9
500	TOTAL RECLASSIFICATIONS					8,465,155		500
	CODE LETTER - C							
1	HOUSEKEEPING	D	HOUSEKEEPING	9	19,211			1
500	TOTAL RECLASSIFICATIONS				19,211			500
	CODE LETTER - D							
1	CAPITAL RELATED RECLASS	E	ADMINISTRATIVE & GENERAL	5		89,696		1
2								2
3	HOME OFFICE DEPRECIATION EXPENSE	E	ADMINISTRATIVE & GENERAL	5		1,635,704	14	3
4	BUILDING DEPRECIATE RECLASS TO EQUI	E	CAP REL COSTS-BLDG & FIXT	1		3,335,128	14	4
500	TOTAL RECLASSIFICATIONS					5,060,528		500
	CODE LETTER - E							
1	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	5,466	162,802		1
2	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	335	11,822		2
3	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	2,012	63,242		3
4	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	2,427	65,340		4
5	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	2,638	60,175		5
6	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	4,194	85,610		6
7	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	27	2,440		7
8	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	722	16,476		8
9	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	239	21,717		9
10	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	1,031	31,741		10
11	MOB	G	PHYSICIANS' PRIVATE OFFICES	192	1,876	66,152		11
12			PHYSICIANS' PRIVATE OFFICES	192	2,160	57,326		12
500	TOTAL RECLASSIFICATIONS				23,127	644,843		500
	CODE LETTER - G							
1	NURSERY RECLASS	H	ADULTS & PEDIATRICS	30	928,324	88,269		1
500	TOTAL RECLASSIFICATIONS				928,324	88,269		500
	CODE LETTER - H							

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	MED ED RECLASS	I	EMERGENCY	91	50,261		1
2			EMERGENCY	91		6,500	2
3			EMERGENCY	91		7,500	3
500	TOTAL RECLASSIFICATIONS				50,261	14,000	500
	CODE LETTER - I						
1	DIETARY RECLASS	J	DIETARY	10	2,247	1,403,824	1
2							2
500	TOTAL RECLASSIFICATIONS				2,247	1,403,824	500
	CODE LETTER - J						
1	ACCT 615200 RECL SALARY TO NON	K	ADMINISTRATIVE & GENERAL	5		1,500	1
2	ACCT 615200 RECL SALARY TO NON	K	RADIOLOGY-DIAGNOSTIC	54	37,400		2
3	ACCT 615200 RECL SALARY TO NON	K	RADIOLOGY-THERAPEUTIC	55		3,795	3
4	ACCT 615200 RECL SALARY TO NON	K	EMERGENCY	91	700		4
5	ACCT 615200 RECL SALARY TO NON	K	HOME HEALTH AGENCY	101	76,079		5
6	ACCT 744000 RECL CC 3016 NON TO SAL	K	ADMINISTRATIVE & GENERAL	5		741,038	6
7	ACCT 744000 RECL CC 3340 NON TO SAL	K	ADMINISTRATIVE & GENERAL	5		55,544	7
8	ACCT 744000 RECL CC 3260 NON TO SAL	K	WOUND CLINIC	90.02		45,239	8
9	RECLASS TO EMERGENCY LINE	K	PHYSICIANS' PRIVATE OFFICES	192	2,776,585	49,323	9
500	TOTAL RECLASSIFICATIONS				2,890,764	896,439	500
	CODE LETTER - K						
	GRAND TOTAL (DECREASES)				3,913,934	30,192,521	

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	55,533,262					55,533,262		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	159,478,223	1,548,902		1,548,902	249,778	160,777,347		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	31,205,334	2,896,875		2,896,875	1,087,414	33,014,795		5
6	MOVABLE EQUIPMENT								6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	246,216,819	4,445,777		4,445,777	1,337,192	249,325,404		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	246,216,819	4,445,777		4,445,777	1,337,192	249,325,404		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	12,943,252						12,943,252	1
2	CAP REL COSTS-MVBLE EQUIP	8,325,093						8,325,093	2
3	TOTAL (SUM OF LINES 1-2)	21,268,345						21,268,345	3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	ALLOCATION OF OTHER CAPITAL INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8	
1	CAP REL COSTS-BLDG & FIXT	12,943,252		12,943,252	0.608569					1
2	CAP REL COSTS-MVBLE EQUIP	8,325,093		8,325,093	0.391431					2
3	TOTAL (SUM OF LINES 1-2)	21,268,345		21,268,345	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(2) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	12,943,252					-3,335,128	9,608,124	1
2	CAP REL COSTS-MVBLE EQUIP	8,325,093					-2,145,152	6,179,941	2
3	TOTAL	21,268,345					-5,480,280	15,788,065	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	-6,471,200				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	2,271,995				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS						14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	-7,115,984	CAP REL COSTS-MVBLE EQUIP	2	14	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	FOOD INCOME	B	-616,504	DIETARY	10		33
33.03	FOOD INCOME	B	-311,436	CAFETERIA	11		33.03
33.04	FOOD INCOME	B	-138,842	HEALTH & FITNESS CENTER	194		33.04
33.05	OTHER FOOD SERVICE	B	-8,803	DIETARY	10		33.05
34	HFI	B	-7,646,523	HEALTH & FITNESS CENTER	194		34
35	BUILDING RENTALS	B	-78,073	PHYSICIANS' PRIVATE OFFICES	192		35
36	ACCT615221 NMFF CLIN BASE NO HOURS	A	-1,103,087	ADMINISTRATIVE & GENERAL	5		36
37	MISC	B	-132,642	ADMINISTRATIVE & GENERAL	5		37
37.01	MISC	B	748	PHARMACY	15		37.01
37.02	MISC	B	52,821	PHYSICIANS' PRIVATE OFFICES	192		37.02
37.03	MISC	B	-1,381	HEALTH & FITNESS CENTER	194		37.03
37.05	OTHER INCOME	B	3	MAINTENANCE OF PERSONNEL	12		37.05
37.06	OTHER INCOME	B	-43,680	OPERATING ROOM	50		37.06
37.07	OTHER INCOME	B	-83,519	RADIOLOGY-DIAGNOSTIC	54		37.07
37.08	OTHER INCOME	B	-15	MRI	58		37.08
37.09	OTHER INCOME	B	-21,097	LABORATORY	60		37.09
37.10	OTHER INCOME	B	-6,408	PHYSICAL THERAPY	66		37.10
37.11	OTHER INCOME	B	-7,024	SPEECH PATHOLOGY	68		37.11
37.12	OTHER INCOME	B	-22,927	ELECTROCARDIOLOGY	69		37.12
37.13	OTHER INCOME	B	-4,526	EMERGENCY	91		37.13
37.14	OTHER INCOME	B	2,515	PHYSICIANS' PRIVATE OFFICES	192		37.14
37.16	OTHER INCOME	B	-242	HEALTH & FITNESS CENTER	194		37.16
37.17	OTHER OP REV	B	-431,007	ADMINISTRATIVE & GENERAL	5		37.17
37.18	OTHER OP REV	B	-1,591	OPERATION OF PLANT	7		37.18
37.19	OTHER OP REV	B	-301	LAUNDRY & LINEN SERVICE	8		37.19
37.20	OTHER OP REV	B	-9,342	DIETARY	10		37.20
37.21	OTHER OP REV	B	-206	CENTRAL SERVICES & SUPPLY	14		37.21
37.22	OTHER OP REV	B	3,714	MEDICAL RECORDS & LIBRARY	16		37.22
37.23	OTHER OP REV	B	-2,076	ADULTS & PEDIATRICS	30		37.23

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	
37.25	OTHER OP REV	B	-65,945	DELIVERY ROOM & LABOR ROOM	52		37.25
37.26	OTHER OP REV	B	-164	RADIOLOGY-DIAGNOSTIC	54		37.26
37.27	OTHER OP REV	B	-475	RADIOLOGY-THERAPEUTIC	55		37.27
37.28	OTHER OP REV	B	-2,838	LABORATORY	60		37.28
37.29	OTHER OP REV	B	-7,927	PHYSICAL THERAPY	66		37.29
37.30	OTHER OP REV	B	-8,004	CARDIAC REHABILITATION	76.97		37.30
37.31	OTHER OP REV	B	-1,509,656	HOME HEALTH AGENCY	101		37.31
37.32	OTHER OP REV	B	-635,398	GIFT, FLOWER, COFFEE SHOP & CAN	190		37.32
37.33	OTHER OP REV	B	-51,013	PHYSICIANS' PRIVATE OFFICES	192		37.33
37.34	OTHER OP REV	B	-119	OCCUPATIONAL HEALTH	194.01		37.34
37.35	RENTAL INCOME	B	-1,067,638	ADMINISTRATIVE & GENERAL	5		37.35
37.36	RENTAL INCOME	B	-58,677	MAINTENANCE OF PERSONNEL	12		37.36
37.37	RENTAL INCOME	B	-132,289	NURSING FACILITY	45		37.37
37.38	RENTAL INCOME	B	-669,848	GIFT, FLOWER, COFFEE SHOP & CAN	190		37.38
37.39	RENTAL INCOME	B	-5,773,743	PHYSICIANS' PRIVATE OFFICES	192		37.39
37.40	RENTAL INCOME	B	-6,446	HEALTH & FITNESS CENTER	194		37.40
38	OTHER INCOME	B	-35,981	ADMINISTRATIVE & GENERAL	5		38
39	OTHER INCOME	B	-3	HOUSEKEEPING	9		39
40	OTHER INCOME	B	-175,934	DIETARY	10		40
41	CC3291PARTB PHYSICIAN NON SALARY	A	-509,589	EMERGENCY	91		41
42	OFFSET LIMITED TO COST	B	923,171	HEALTH & FITNESS CENTER	194		42
42.01	LIMITED TO COST	B	2,825,908	PHYSICIANS' PRIVATE OFFICES	192		42.01
43	CC3551PARTBPHYSICIAN NON SALARY	A	-49,323	EMERGENCY	91		43
44	OFFSET LIMITED TO COST	B	164,184	GIFT, FLOWER, COFFEE SHOP & CAN	190		44
45	OFFSET LIMITED TO COST	B	1,557,560	PHYSICIANS' PRIVATE OFFICES	192		45
45.01	OFFSET HAP ASSESSMENT (PARTIAL)	A	-2,971,474	ADMINISTRATIVE & GENERAL	5		45.01
46	IC INTEREST EXPENSE	A	-1,458,821	ADMINISTRATIVE & GENERAL	5		46
47	REAL ESTATE TAXES	A	-34,138	EMPLOYEE BENEFITS DEPARTMENT	4		47
48	REAL ESTATE TAXES	A	-10,845	MAINTENANCE OF PERSONNEL	12		48
48.01	REAL ESTATE TAXES	A	-1,049,337	PHYSICIANS' PRIVATE OFFICES	192		48.01
49	REAL ESTATE TAXES	A	-303,991	HEALTH & FITNESS CENTER	194		49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-33,045,433				50

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ-USTMENTS (COL. 4-5)	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES NMHC	21,458,048	19,186,053	2,271,995		1
2	54	RADIOLOGY-DIAGNOSTIC	VARIOUS NMH	182,069	182,069			2
3	60	LABORATORY	VARIOUS NMH	544,273	544,273			3
3.01	91	EMERGENCY	VARIOUS NMC	18,875	18,875			4.01
3.02	5	ADMINISTRATIVE & GENERAL	VARIOUS NMPG	6,050,393	6,050,393			4.02
3.03	4	EMPLOYEE BENEFITS DEPARTMENT	VARIOUS NMPG	199,620	199,620			4.03
3.04	15	PHARMACY	VARIOUS NMH	183,440	183,440			4.04
3.05	14	CENTRAL SERVICES & SUPPLY	VARIOUS NMHC	109,104	109,104			4.05
3.06	55	RADIOLOGY-THERAPEUTIC	VARIOUS NMH	180,000	180,000			4.06
3.07	58	MRI	VARIOUS NMH	10,915	10,915			4.07
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		28,936,737	26,664,742	2,271,995		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.

	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
6	B			NM HEALTHCARE	HEALTHCARE		6
7	B			NM HOSPITAL	HEALTHCARE		7
8	B			NM PHYSICIANSGROUP	HEALTHCARE		8
9	B			NM INSURANCE CO	HEALTHCARE		9
9.01	B			NHC	HEALTHCARE		10.01
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	4	EMPLOYEE BENEFITS DEPART									1
2	5	ADMINISTRATIVE & GENERAL		898,471		898,471	177,200	6,177	526,233	26,312	2
3	90.02	WOUND CLINIC		45,239		45,239	165,600	344	27,388	1,369	3
4	16	MEDICAL RECORDS & LIBRAR									4
5	45	NURSING FACILITY									5
6	52	DELIVERY ROOM & LABOR RO									6
7	54	RADIOLOGY-DIAGNOSTIC									7
8	60	LABORATORY									8
9	66	PHYSICAL THERAPY									9
10	69	ELECTROCARDIOLOGY									10
11	91	EMERGENCY		120,300		120,300	177,200	915	77,951	3,898	11
12	91	EMERGENCY	CC 3551	2,776,585	2,776,585		177,200	1	85	4	12
13	91	EMERGENCY	CC3291 MINUS PA	3,262,177	3,262,177		177,200	1	85	4	13
200		TOTAL		7,102,772	6,038,762	1,064,010		7,438	631,742	31,587	200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18	
1	4	EMPLOYEE BENEFITS DEPART									1
2	5	ADMINISTRATIVE & GENERAL						526,233	372,238	372,238	2
3	90.02	WOUND CLINIC						27,388	17,851	17,851	3
4	16	MEDICAL RECORDS & LIBRAR									4
5	45	NURSING FACILITY									5
6	52	DELIVERY ROOM & LABOR RO									6
7	54	RADIOLOGY-DIAGNOSTIC									7
8	60	LABORATORY									8
9	66	PHYSICAL THERAPY									9
10	69	ELECTROCARDIOLOGY									10
11	91	EMERGENCY						77,951	42,349	42,349	11
12	91	EMERGENCY	CC 3551					85		2,776,585	12
13	91	EMERGENCY	CC3291 MINUS PA					85		3,262,177	13
200		TOTAL						631,742	432,438	6,471,200	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	9,608,124	9,608,124				1
2	CAP REL COSTS-MVBLE EQUIP	6,179,941		6,179,941			2
4	EMPLOYEE BENEFITS DEPARTMENT	14,430,739	85,559		14,516,298		4
5	ADMINISTRATIVE & GENERAL	55,512,737	598,113	211,184	2,568,965	58,890,999	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	9,319,139	1,656,124	121,604	432,909	11,529,776	7
8	LAUNDRY & LINEN SERVICE	464,098	24,343	9,443	48,315	546,199	8
9	HOUSEKEEPING	2,511,273	79,178	8,009	246,162	2,844,622	9
10	DIETARY	2,040,952	66,189		1,311	2,108,452	10
11	CAFETERIA	975,671	16,065			991,736	11
12	MAINTENANCE OF PERSONNEL	310,262	89,452		3,622	403,336	12
13	NURSING ADMINISTRATION	2,845,090	16,577		420,110	3,281,777	13
14	CENTRAL SERVICES & SUPPLY	764,766	128,098	77,430	115,213	1,085,507	14
15	PHARMACY	1,883,684	28,040	8,870	269,832	2,190,426	15
16	MEDICAL RECORDS & LIBRARY	715,964	36,457	1,050	107,897	861,368	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	50,261				50,261	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	14,000				14,000	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,768,032	235,441	22,389	1,926,118	12,951,980	30
31	INTENSIVE CARE UNIT	2,138,408	42,325	2,742	315,708	2,499,183	31
43	NURSERY	1,815,787	5,010	1,352	129,877	1,952,026	43
44	SKILLED NURSING FACILITY	2,787,799	141,065	1,783	456,105	3,386,752	44
45	NURSING FACILITY	2,531,505	537,562	1,617	249,797	3,320,481	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,610,347	616,957	1,372,860	1,346,227	12,946,391	50
52	DELIVERY ROOM & LABOR ROOM	2,777,315	78,177	24,659	431,256	3,311,407	52
54	RADIOLOGY-DIAGNOSTIC	9,561,019	260,694	1,924,883	1,060,583	12,807,179	54
55	RADIOLOGY-THERAPEUTIC	1,073,802	116,049	1,144,221	133,506	2,467,578	55
57	CT SCAN	1,096,151	10,065	5,787	111,301	1,223,304	57
58	MRI	1,750,622	160,367	653,490	279,673	2,844,152	58
59	CARDIAC CATHETERIZATION	798,342	29,631	88,795	108,920	1,025,688	59
60	LABORATORY	7,756,308	121,349	219,232	532,070	8,628,959	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,001,660	1,912	3,294	152,095	1,158,961	65
66	PHYSICAL THERAPY	3,352,108	163,567		577,646	4,093,321	66
68	SPEECH PATHOLOGY	1,253,668	141,869	29,652	161,740	1,586,929	68
69	ELECTROCARDIOLOGY	613,659	49,409	113,443	105,654	882,165	69
70	ELECTROENCEPHALOGRAPHY	218,424	31,477		36,667	286,568	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,900,328				6,900,328	71
72	IMPL. DEV. CHARGED TO PATIENTS	6,719,135				6,719,135	72
73	DRUGS CHARGED TO PATIENTS	8,465,155				8,465,155	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	442,489	8,563	38,594	74,930	564,576	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	539,878	76,313		85,042	701,233	90.01
90.02	WOUND CLINIC	821,576	12,391	11,626	54,837	900,430	90.02
91	EMERGENCY	5,636,395	191,831	42,135	1,456,578	7,326,939	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT	6,563		4,428		10,991	92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	1,954,057	54,730		444,176	2,452,963	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	200,017,233	5,910,949	6,144,572	14,444,842	196,213,233	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,261	495	71,456	80,212	190
192	PHYSICIANS' PRIVATE OFFICES		3,126,926			3,126,926	192
194	HEALTH & FITNESS CENTER		543,972	33,562		577,534	194
194.01	OCCUPATIONAL HEALTH	43,813	18,016	1,312		63,141	194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	200,061,046	9,608,124	6,179,941	14,516,298	200,061,046	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL	58,890,999					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	4,809,807	16,339,583				7
8	LAUNDRY & LINEN SERVICE	227,855	208,909	982,963			8
9	HOUSEKEEPING	1,186,674	160,576	491,481	4,683,353		9
10	DIETARY	879,570	568,056		71,393	3,627,471	10
11	CAFETERIA	413,717	47,059		19,039		11
12	MAINTENANCE OF PERSONNEL	168,257	767,667		9,519		12
13	NURSING ADMINISTRATION	1,369,039	142,262				13
14	CENTRAL SERVICES & SUPPLY	452,834	332,621		47,595		14
15	PHARMACY	913,767	118,756		28,557		15
16	MEDICAL RECORDS & LIBRARY	359,332	312,891		104,709		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	20,967					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,840					22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,403,039	2,020,553	268,806	2,674,839	3,298,331	30
31	INTENSIVE CARE UNIT	1,042,569	363,254	29,758	214,178	329,140	31
43	NURSERY	814,315	43,000	68,216	66,633		43
44	SKILLED NURSING FACILITY	1,412,831	1,210,642	7,239	152,304		44
45	NURSING FACILITY	1,385,185	2,026,075	43,867			45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	5,400,768	2,217,045	16,793	494,989		50
52	DELIVERY ROOM & LABOR ROOM	1,381,400	670,906	20,270			52
54	RADIOLOGY-DIAGNOSTIC	5,342,694	957,129		114,228		54
55	RADIOLOGY-THERAPEUTIC	1,029,385	302,082				55
57	CT SCAN	510,318	86,377				57
58	MRI	1,186,478	86,471				58
59	CARDIAC CATHETERIZATION	427,880	254,316				59
60	LABORATORY	3,599,691	624,366		142,785		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	483,477	16,426		42,836		65
66	PHYSICAL THERAPY	1,707,586	899,639	4,166	52,355		66
68	SPEECH PATHOLOGY	662,010	212,543				68
69	ELECTROCARDIOLOGY	368,007	49,419				69
70	ELECTROENCEPHALOGRAPHY	119,546	270,128				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,878,568					71
72	IMPL. DEV. CHARGED TO PATIENTS	2,802,981					72
73	DRUGS CHARGED TO PATIENTS	3,531,358					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	235,521	73,491	2,024			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	292,529	203,198		223,697		90.01
90.02	WOUND CLINIC	375,627	106,342				90.02
91	EMERGENCY	3,056,535	912,524	30,343	185,621		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT	4,585					92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	1,023,288	3,965				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	57,285,830	16,268,688	982,963	4,645,277	3,627,471	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,462	70,895		38,076		190
192	PHYSICIANS' PRIVATE OFFICES	1,304,441					192
194	HEALTH & FITNESS CENTER	240,926					194
194.01	OCCUPATIONAL HEALTH	26,340					194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	58,890,999	16,339,583	982,963	4,683,353	3,627,471	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11	12	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	1,471,551					11
12	MAINTENANCE OF PERSONNEL	751	1,349,530				12
13	NURSING ADMINISTRATION	39,012		4,832,090			13
14	CENTRAL SERVICES & SUPPLY	29,887			1,948,444		14
15	PHARMACY	28,464			15,970	3,295,940	15
16	MEDICAL RECORDS & LIBRARY	20,217			53,712		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	33,243					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	276,986	674,766	1,524,964	59,822	191,012	30
31	INTENSIVE CARE UNIT	38,533		252,563	9,888	47,811	31
43	NURSERY	12,658		127,673	9,042	3,709	43
44	SKILLED NURSING FACILITY	64,456		336,030	14,205	40,964	44
45	NURSING FACILITY	52,469		60,127		6,877	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	185,472			1,061,242	1,735,397	50
52	DELIVERY ROOM & LABOR ROOM	51,382		1,412,438	33,638	71,171	52
54	RADIOLOGY-DIAGNOSTIC	126,994		87,485	214,846	130,546	54
55	RADIOLOGY-THERAPEUTIC	15,359		14,529	3,289	3,218	55
57	CT SCAN	15,039		6,028	10,183	1,437	57
58	MRI	32,827		1,391	28,859	16,061	58
59	CARDIAC CATHETERIZATION	10,724		61,672	111,140	38,530	59
60	LABORATORY	92,584	168,691		215,626	84,660	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	18,651			10,378	12,539	65
66	PHYSICAL THERAPY	67,380	168,691		2,592	325	66
68	SPEECH PATHOLOGY	22,695			26,391		68
69	ELECTROCARDIOLOGY	13,377			1,978	15,559	69
70	ELECTROENCEPHALOGRAPHY	5,258			621		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	8,902		42,197	1,643	1,194	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	10,261		54,253	2,250	78,765	90.01
90.02	WOUND CLINIC	7,480		14,838	13,795	29,284	90.02
91	EMERGENCY	132,268	337,382	626,308	47,322	786,378	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT				12		92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	49,560		209,130		503	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,462,889	1,349,530	4,831,626	1,948,444	3,295,940	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,662					190
192	PHYSICIANS' PRIVATE OFFICES						192
194	HEALTH & FITNESS CENTER						194
194.01	OCCUPATIONAL HEALTH			464			194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,471,551	1,349,530	4,832,090	1,948,444	3,295,940	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	I&R SALARY & FRINGES 21	I&R 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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	1,712,229					16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD		104,471				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			19,840			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	115,576			29,460,674		30
31	INTENSIVE CARE UNIT	22,982			4,849,859		31
43	NURSERY	15,835			3,113,107		43
44	SKILLED NURSING FACILITY	21,850			6,647,273		44
45	NURSING FACILITY				6,895,081		45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	286,235			24,344,332		50
52	DELIVERY ROOM & LABOR ROOM	29,935			6,982,547		52
54	RADIOLOGY-DIAGNOSTIC	249,682			20,030,783		54
55	RADIOLOGY-THERAPEUTIC	48,846			3,884,286		55
57	CT SCAN	93,679			1,946,365		57
58	MRI	153,156			4,349,395		58
59	CARDIAC CATHETERIZATION	30,949			1,960,899		59
60	LABORATORY	212,000			13,769,362		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	24,132			1,767,400		65
66	PHYSICAL THERAPY	42,737			7,038,792		66
68	SPEECH PATHOLOGY	12,188			2,522,756		68
69	ELECTROCARDIOLOGY	56,363			1,386,868		69
70	ELECTROENCEPHALOGRAPHY	2,102			684,223		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				9,778,896		71
72	IMPL. DEV. CHARGED TO PATIENTS				9,522,116		72
73	DRUGS CHARGED TO PATIENTS				11,996,513		73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	3,427			932,975		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	7,721			1,573,907		90.01
90.02	WOUND CLINIC	6,500			1,454,296		90.02
91	EMERGENCY	261,423	104,471	19,840	13,827,354	-124,311	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT	526			16,114		92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	14,385			3,753,794		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,712,229	104,471	19,840	194,489,967	-124,311	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				231,307		190
192	PHYSICIANS' PRIVATE OFFICES				4,431,367		192
194	HEALTH & FITNESS CENTER				818,460		194
194.01	OCCUPATIONAL HEALTH				89,945		194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,712,229	104,471	19,840	200,061,046	-124,311	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	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES 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	29,460,674	30
31	INTENSIVE CARE UNIT	4,849,859	31
43	NURSERY	3,113,107	43
44	SKILLED NURSING FACILITY	6,647,273	44
45	NURSING FACILITY	6,895,081	45
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	24,344,332	50
52	DELIVERY ROOM & LABOR ROOM	6,982,547	52
54	RADIOLOGY-DIAGNOSTIC	20,030,783	54
55	RADIOLOGY-THERAPEUTIC	3,884,286	55
57	CT SCAN	1,946,365	57
58	MRI	4,349,395	58
59	CARDIAC CATHETERIZATION	1,960,899	59
60	LABORATORY	13,769,362	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	1,767,400	65
66	PHYSICAL THERAPY	7,038,792	66
68	SPEECH PATHOLOGY	2,522,756	68
69	ELECTROCARDIOLOGY	1,386,868	69
70	ELECTROENCEPHALOGRAPHY	684,223	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,778,896	71
72	IMPL. DEV. CHARGED TO PATIENTS	9,522,116	72
73	DRUGS CHARGED TO PATIENTS	11,996,513	73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION	932,975	76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90.01	OP PEDS ONC CLINIC	1,573,907	90.01
90.02	WOUND CLINIC	1,454,296	90.02
91	EMERGENCY	13,703,043	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
92.01	OBSERVATION BEDS-DISTINCT	16,114	92.01
	OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS		94
101	HOME HEALTH AGENCY	3,753,794	101
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	194,365,656	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	231,307	190
192	PHYSICIANS' PRIVATE OFFICES	4,431,367	192
194	HEALTH & FITNESS CENTER	818,460	194
194.01	OCCUPATIONAL HEALTH	89,945	194.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	199,936,735	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		85,559		85,559	85,559	4
5	ADMINISTRATIVE & GENERAL		598,113	211,184	809,297	15,111	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		1,656,124	121,604	1,777,728	2,553	7
8	LAUNDRY & LINEN SERVICE		24,343	9,443	33,786	285	8
9	HOUSEKEEPING		79,178	8,009	87,187	1,452	9
10	DIETARY		66,189		66,189	8	10
11	CAFETERIA		16,065		16,065		11
12	MAINTENANCE OF PERSONNEL		89,452		89,452	21	12
13	NURSING ADMINISTRATION		16,577		16,577	2,477	13
14	CENTRAL SERVICES & SUPPLY		128,098	77,430	205,528	679	14
15	PHARMACY		28,040	8,870	36,910	1,591	15
16	MEDICAL RECORDS & LIBRARY		36,457	1,050	37,507	636	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		235,441	22,389	257,830	11,358	30
31	INTENSIVE CARE UNIT		42,325	2,742	45,067	1,862	31
43	NURSERY		5,010	1,352	6,362	766	43
44	SKILLED NURSING FACILITY		141,065	1,783	142,848	2,690	44
45	NURSING FACILITY		537,562	1,617	539,179	1,473	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		616,957	1,372,860	1,989,817	7,938	50
52	DELIVERY ROOM & LABOR ROOM		78,177	24,659	102,836	2,543	52
54	RADIOLOGY-DIAGNOSTIC		260,694	1,924,883	2,185,577	6,254	54
55	RADIOLOGY-THERAPEUTIC		116,049	1,144,221	1,260,270	787	55
57	CT SCAN		10,065	5,787	15,852	656	57
58	MRI		160,367	653,490	813,857	1,649	58
59	CARDIAC CATHETERIZATION		29,631	88,795	118,426	642	59
60	LABORATORY		121,349	219,232	340,581	3,137	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,912	3,294	5,206	897	65
66	PHYSICAL THERAPY		163,567		163,567	3,406	66
68	SPEECH PATHOLOGY		141,869	29,652	171,521	954	68
69	ELECTROCARDIOLOGY		49,409	113,443	162,852	623	69
70	ELECTROENCEPHALOGRAPHY		31,477		31,477	216	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		8,563	38,594	47,157	442	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC		76,313		76,313	501	90.01
90.02	WOUND CLINIC		12,391	11,626	24,017	323	90.02
91	EMERGENCY		191,831	42,135	233,966	8,589	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT			4,428	4,428		92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		54,730		54,730	2,619	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		5,910,949	6,144,572	12,055,521	85,138	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		8,261	495	8,756	421	190
192	PHYSICIANS' PRIVATE OFFICES		3,126,926		3,126,926		192
194	HEALTH & FITNESS CENTER		543,972	33,562	577,534		194
194.01	OCCUPATIONAL HEALTH		18,016	1,312	19,328		194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		9,608,124	6,179,941	15,788,065	85,559	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL	824,408					5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	67,334	1,847,615				7
8	LAUNDRY & LINEN SERVICE	3,190	23,623	60,884			8
9	HOUSEKEEPING	16,613	18,157	30,443	153,852		9
10	DIETARY	12,313	64,234		2,345	145,089	10
11	CAFETERIA	5,792	5,321		625		11
12	MAINTENANCE OF PERSONNEL	2,355	86,805		313		12
13	NURSING ADMINISTRATION	19,166	16,086				13
14	CENTRAL SERVICES & SUPPLY	6,339	37,611		1,564		14
15	PHARMACY	12,792	13,428		938		15
16	MEDICAL RECORDS & LIBRARY	5,030	35,380		3,440		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	294					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	82					22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	75,612	228,476	16,650	87,870	131,924	30
31	INTENSIVE CARE UNIT	14,595	41,075	1,843	7,036	13,165	31
43	NURSERY	11,400	4,862	4,225	2,189		43
44	SKILLED NURSING FACILITY	19,779	136,895	448	5,003		44
45	NURSING FACILITY	19,392	229,101	2,717			45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	75,607	250,695	1,040	16,261		50
52	DELIVERY ROOM & LABOR ROOM	19,339	75,863	1,256			52
54	RADIOLOGY-DIAGNOSTIC	74,794	108,228		3,752		54
55	RADIOLOGY-THERAPEUTIC	14,411	34,158				55
57	CT SCAN	7,144	9,767				57
58	MRI	16,610	9,778				58
59	CARDIAC CATHETERIZATION	5,990	28,757				59
60	LABORATORY	50,393	70,601		4,691		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	6,768	1,857		1,407		65
66	PHYSICAL THERAPY	23,905	101,728	258	1,720		66
68	SPEECH PATHOLOGY	9,268	24,034				68
69	ELECTROCARDIOLOGY	5,152	5,588				69
70	ELECTROENCEPHALOGRAPHY	1,674	30,545				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,298					71
72	IMPL. DEV. CHARGED TO PATIENTS	39,240					72
73	DRUGS CHARGED TO PATIENTS	49,437					73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	3,297	8,310	125			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	4,095	22,977		7,349		90.01
90.02	WOUND CLINIC	5,259	12,025				90.02
91	EMERGENCY	42,789	103,185	1,879	6,098		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT	64					92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	14,325	448				101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	801,937	1,839,598	60,884	152,601	145,089	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	468	8,017		1,251		190
192	PHYSICIANS' PRIVATE OFFICES	18,261					192
194	HEALTH & FITNESS CENTER	3,373					194
194.01	OCCUPATIONAL HEALTH	369					194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	824,408	1,847,615	60,884	153,852	145,089	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11	12	13	14	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	27,803					11
12	MAINTENANCE OF PERSONNEL	14	178,960				12
13	NURSING ADMINISTRATION	737		55,043			13
14	CENTRAL SERVICES & SUPPLY	565			252,286		14
15	PHARMACY	538			2,061	68,258	15
16	MEDICAL RECORDS & LIBRARY	382			6,931		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD	628					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	5,235	89,480	17,370	7,719	3,956	30
31	INTENSIVE CARE UNIT	728		2,877	1,276	990	31
43	NURSERY	239		1,454	1,167	77	43
44	SKILLED NURSING FACILITY	1,218		3,828	1,833	848	44
45	NURSING FACILITY	991		685		142	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,504			137,808	35,939	50
52	DELIVERY ROOM & LABOR ROOM	971		16,089	4,340	1,474	52
54	RADIOLOGY-DIAGNOSTIC	2,399		997	27,722	2,704	54
55	RADIOLOGY-THERAPEUTIC	290		166	424	67	55
57	CT SCAN	284		69	1,314	30	57
58	MRI	620		16	3,724	333	58
59	CARDIAC CATHETERIZATION	203		703	14,341	798	59
60	LABORATORY	1,749	22,370		27,823	1,753	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	352			1,339	260	65
66	PHYSICAL THERAPY	1,273	22,370		334	7	66
68	SPEECH PATHOLOGY	429			3,405		68
69	ELECTROCARDIOLOGY	253			255	322	69
70	ELECTROENCEPHALOGRAPHY	99			80		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	168		481	212	25	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	194		618	290	1,631	90.01
90.02	WOUND CLINIC	141		169	1,780	606	90.02
91	EMERGENCY	2,499	44,740	7,134	6,106	16,286	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT				2		92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	936		2,382		10	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	27,639	178,960	55,038	252,286	68,258	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	164					190
192	PHYSICIANS' PRIVATE OFFICES						192
194	HEALTH & FITNESS CENTER						194
194.01	OCCUPATIONAL HEALTH			5			194.01
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	27,803	178,960	55,043	252,286	68,258	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	COST CENTER DESCRIPTION	MEDICAL RECORDS + LIBRARY 16	I&R SALARY & FRINGES 21	I&R 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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	89,306					16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD		922				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			82			22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	6,035			939,515		30
31	INTENSIVE CARE UNIT	1,200			131,714		31
43	NURSERY	827			33,568		43
44	SKILLED NURSING FACILITY	1,141			316,531		44
45	NURSING FACILITY				793,680		45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	14,845			2,533,454		50
52	DELIVERY ROOM & LABOR ROOM	1,563			226,274		52
54	RADIOLOGY-DIAGNOSTIC	13,038			2,425,465		54
55	RADIOLOGY-THERAPEUTIC	2,551			1,313,124		55
57	CT SCAN	4,892			40,008		57
58	MRI	7,997			854,584		58
59	CARDIAC CATHETERIZATION	1,616			171,476		59
60	LABORATORY	11,070			534,168		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,260			19,346		65
66	PHYSICAL THERAPY	2,232			320,800		66
68	SPEECH PATHOLOGY	636			210,247		68
69	ELECTROCARDIOLOGY	2,943			177,988		69
70	ELECTROENCEPHALOGRAPHY	110			64,201		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				40,298		71
72	IMPL. DEV. CHARGED TO PATIENTS				39,240		72
73	DRUGS CHARGED TO PATIENTS				49,437		73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	179			60,396		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	403			114,371		90.01
90.02	WOUND CLINIC	339			44,659		90.02
91	EMERGENCY	13,651			486,922		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT	27			4,521		92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	751			76,201		101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	89,306			12,022,188		118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				19,077		190
192	PHYSICIANS' PRIVATE OFFICES				3,145,187		192
194	HEALTH & FITNESS CENTER				580,907		194
194.01	OCCUPATIONAL HEALTH				19,702		194.01
200	CROSS FOOT ADJUSTMENTS		922	82	1,004		200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	89,306	922	82	15,788,065		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	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SERVICES-SALARY & FRINGES 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	939,515	30
31	INTENSIVE CARE UNIT	131,714	31
43	NURSERY	33,568	43
44	SKILLED NURSING FACILITY	316,531	44
45	NURSING FACILITY	793,680	45
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	2,533,454	50
52	DELIVERY ROOM & LABOR ROOM	226,274	52
54	RADIOLOGY-DIAGNOSTIC	2,425,465	54
55	RADIOLOGY-THERAPEUTIC	1,313,124	55
57	CT SCAN	40,008	57
58	MRI	854,584	58
59	CARDIAC CATHETERIZATION	171,476	59
60	LABORATORY	534,168	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	19,346	65
66	PHYSICAL THERAPY	320,800	66
68	SPEECH PATHOLOGY	210,247	68
69	ELECTROCARDIOLOGY	177,988	69
70	ELECTROENCEPHALOGRAPHY	64,201	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	40,298	71
72	IMPL. DEV. CHARGED TO PATIENTS	39,240	72
73	DRUGS CHARGED TO PATIENTS	49,437	73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION	60,396	76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
90.01	OP PEDS ONC CLINIC	114,371	90.01
90.02	WOUND CLINIC	44,659	90.02
91	EMERGENCY	486,922	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		92
92.01	OBSERVATION BEDS-DISTINCT	4,521	92.01
	OTHER REIMBURSABLE COST CENTERS		
94	HOME PROGRAM DIALYSIS		94
101	HOME HEALTH AGENCY	76,201	101
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	12,022,188	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,077	190
192	PHYSICIANS' PRIVATE OFFICES	3,145,187	192
194	HEALTH & FITNESS CENTER	580,907	194
194.01	OCCUPATIONAL HEALTH	19,702	194.01
200	CROSS FOOT ADJUSTMENTS	1,004	200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	15,788,065	202

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	9,548,773					1
2	CAP REL COSTS-MVBLE EQUIP		4,544,239				2
4	EMPLOYEE BENEFITS DEPARTMENT	85,030		81,522,230			4
5	ADMINISTRATIVE & GENERAL	594,418	155,288	14,427,250	-58,890,999	141,170,047	5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,645,893	89,418	2,431,170		11,529,776	7
8	LAUNDRY & LINEN SERVICE	24,193	6,944	271,333		546,199	8
9	HOUSEKEEPING	78,689	5,889	1,382,421		2,844,622	9
10	DIETARY	65,780		7,361		2,108,452	10
11	CAFETERIA	15,966				991,736	11
12	MAINTENANCE OF PERSONNEL	88,899		20,342		403,336	12
13	NURSING ADMINISTRATION	16,475		2,359,292		3,281,777	13
14	CENTRAL SERVICES & SUPPLY	127,307	56,936	647,026		1,085,507	14
15	PHARMACY	27,867	6,522	1,515,350		2,190,426	15
16	MEDICAL RECORDS & LIBRARY	36,232	772	605,940		861,368	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD					50,261	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					14,000	22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	233,987	16,463	10,816,875		12,951,980	30
31	INTENSIVE CARE UNIT	42,064	2,016	1,772,981		2,499,183	31
43	NURSERY	4,979	994	729,375		1,952,026	43
44	SKILLED NURSING FACILITY	140,194	1,311	2,561,440		3,386,752	44
45	NURSING FACILITY	534,241	1,189	1,402,831		3,320,481	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	613,146	1,009,492	7,560,271		12,946,391	50
52	DELIVERY ROOM & LABOR ROOM	77,694	18,132	2,421,890		3,311,407	52
54	RADIOLOGY-DIAGNOSTIC	259,084	1,415,407	5,956,122		12,807,179	54
55	RADIOLOGY-THERAPEUTIC	115,332	841,369	749,757		2,467,578	55
57	CT SCAN	10,003	4,255	625,057		1,223,304	57
58	MRI	159,376	480,525	1,570,615		2,844,152	58
59	CARDIAC CATHETERIZATION	29,448	65,293	611,683		1,025,688	59
60	LABORATORY	120,599	161,206	2,988,051		8,628,959	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,900	2,422	854,151		1,158,961	65
66	PHYSICAL THERAPY	162,557		3,244,000		4,093,321	66
68	SPEECH PATHOLOGY	140,993	21,804	908,315		1,586,929	68
69	ELECTROCARDIOLOGY	49,104	83,417	593,340		882,165	69
70	ELECTROENCEPHALOGRAPHY	31,283		205,919		286,568	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					6,900,328	71
72	IMPL. DEV. CHARGED TO PATIENTS					6,719,135	72
73	DRUGS CHARGED TO PATIENTS					8,465,155	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	8,510	28,379	420,799		564,576	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	75,842		477,585		701,233	90.01
90.02	WOUND CLINIC	12,314	8,549	307,961		900,430	90.02
91	EMERGENCY	190,646	30,983	8,179,992		7,326,939	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT		3,256			10,991	92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	54,392		2,494,444		2,452,963	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	5,874,437	4,518,231	81,120,939	-58,890,999	137,322,234	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,210	364	401,291		80,212	190
192	PHYSICIANS' PRIVATE OFFICES	3,107,609				3,126,926	192
194	HEALTH & FITNESS CENTER	540,612	24,679			577,534	194
194.01	OCCUPATIONAL HEALTH	17,905	965			63,141	194.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	9,608,124	6,179,941	14,516,298		58,890,999	202
203	UNIT COST MULT-WS B PT I	1.006216	1.359951	0.178066		0.417164	203
204	COST TO BE ALLOC PER B PT II			85,559		824,408	204
205	UNIT COST MULT-WS B PT II			0.001050		0.005840	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	346,175					7
8	LAUNDRY & LINEN SERVICE	4,426	1,228,810				8
9	HOUSEKEEPING	3,402	614,405	4,498,489			9
10	DIETARY	12,035		68,575	73,797		10
11	CAFETERIA	997		18,287		92,075	11
12	MAINTENANCE OF PERSONNEL	16,264		9,143		47	12
13	NURSING ADMINISTRATION	3,014				2,441	13
14	CENTRAL SERVICES & SUPPLY	7,047		45,716		1,870	14
15	PHARMACY	2,516		27,430		1,781	15
16	MEDICAL RECORDS & LIBRARY	6,629		100,576		1,265	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD					2,080	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	42,808	336,037	2,569,258	67,101	17,331	30
31	INTENSIVE CARE UNIT	7,696	37,201	205,724	6,696	2,411	31
43	NURSERY	911	85,277	64,003		792	43
44	SKILLED NURSING FACILITY	25,649	9,049	146,292		4,033	44
45	NURSING FACILITY	42,925	54,838			3,283	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	46,971	20,993	475,450		11,605	50
52	DELIVERY ROOM & LABOR ROOM	14,214	25,340			3,215	52
54	RADIOLOGY-DIAGNOSTIC	20,278		109,719		7,946	54
55	RADIOLOGY-THERAPEUTIC	6,400				961	55
57	CT SCAN	1,830				941	57
58	MRI	1,832				2,054	58
59	CARDIAC CATHETERIZATION	5,388				671	59
60	LABORATORY	13,228		137,149		5,793	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	348		41,145		1,167	65
66	PHYSICAL THERAPY	19,060	5,208	50,288		4,216	66
68	SPEECH PATHOLOGY	4,503				1,420	68
69	ELECTROCARDIOLOGY	1,047				837	69
70	ELECTROENCEPHALOGRAPHY	5,723				329	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	1,557	2,530			557	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	4,305		214,867		642	90.01
90.02	WOUND CLINIC	2,253				468	90.02
91	EMERGENCY	19,333	37,932	178,294		8,276	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT						92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	84				3,101	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	344,673	1,228,810	4,461,916	73,797	91,533	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,502		36,573		542	190
192	PHYSICIANS' PRIVATE OFFICES						192
194	HEALTH & FITNESS CENTER						194
194.01	OCCUPATIONAL HEALTH						194.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		SQUARE FEET	POUNDS OF LAUNDRY	HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	
		7	8	9	10	11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	16,339,583	982,963	4,683,353	3,627,471	1,471,551	202
203	UNIT COST MULT-WS B PT I	47.200355	0.799931	1.041095	49.154722	15.982091	203
204	COST TO BE ALLOC PER B PT II	1,847,615	60,884	153,852	145,089	27,803	204
205	UNIT COST MULT-WS B PT II	5.337228	0.049547	0.034201	1.966056	0.301960	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSNG HRS 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	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL	2,024,160					12
13	NURSING ADMINISTRATION		31,262				13
14	CENTRAL SERVICES & SUPPLY			2,514,887,251			14
15	PHARMACY			20,605,836	57,409,127		15
16	MEDICAL RECORDS & LIBRARY			69,306,331		709,709,380	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	1,012,080	9,866	77,189,202	3,327,090	47,897,195	30
31	INTENSIVE CARE UNIT		1,634	12,759,309	832,791	9,524,414	31
43	NURSERY		826	11,666,824	64,600	6,562,184	43
44	SKILLED NURSING FACILITY		2,174	18,329,008	713,518	9,055,000	44
45	NURSING FACILITY		389		119,779		45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM			1,370,110,122	30,227,215	118,746,089	50
52	DELIVERY ROOM & LABOR ROOM		9,138	43,403,863	1,239,679	12,405,771	52
54	RADIOLOGY-DIAGNOSTIC		566	277,221,223	2,273,881	103,473,593	54
55	RADIOLOGY-THERAPEUTIC		94	4,243,661	56,060	20,242,997	55
57	CT SCAN		39	13,138,885	25,029	38,822,646	57
58	MRI		9	37,237,054	279,753	63,471,114	58
59	CARDIAC CATHETERIZATION		399	143,406,985	671,118	12,825,782	59
60	LABORATORY	253,020		278,227,721	1,474,625	87,857,376	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY			13,391,221	218,411	10,000,975	65
66	PHYSICAL THERAPY	253,020		3,343,978	5,660	17,711,237	66
68	SPEECH PATHOLOGY			34,052,745		5,050,981	68
69	ELECTROCARDIOLOGY			2,552,561	271,006	23,358,162	69
70	ELECTROENCEPHALOGRAPHY			801,400		871,249	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		273	2,120,554	20,789	1,420,289	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC		351	2,903,247	1,371,954	3,199,833	90.01
90.02	WOUND CLINIC		96	17,800,157	510,084	2,693,588	90.02
91	EMERGENCY	506,040	4,052	61,060,183	13,697,332	108,339,520	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
92.01	OBSERVATION BEDS-DISTINCT			15,181		217,784	92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY		1,353		8,753	5,961,601	101
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,024,160	31,259	2,514,887,251	57,409,127	709,709,380	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
194	HEALTH & FITNESS CENTER						194
194.01	OCCUPATIONAL HEALTH		3				194.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 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	1,349,530	4,832,090	1,948,444	3,295,940	1,712,229	202
203	UNIT COST MULT-WS B PT I	0.666711	154.567526	0.000775	0.057411	0.002413	203
204	COST TO BE ALLOC PER B PT II	178,960	55,043	252,286	68,258	89,306	204
205	UNIT COST MULT-WS B PT II	0.088412	1.760700	0.000100	0.001189	0.000126	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R 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	ADMINISTRATIVE & GENERAL			5
6	MAINTENANCE & REPAIRS			6
7	OPERATION OF PLANT			7
8	LAUNDRY & LINEN SERVICE			8
9	HOUSEKEEPING			9
10	DIETARY			10
11	CAFETERIA			11
12	MAINTENANCE OF PERSONNEL			12
13	NURSING ADMINISTRATION			13
14	CENTRAL SERVICES & SUPPLY			14
15	PHARMACY			15
16	MEDICAL RECORDS & LIBRARY			16
17	SOCIAL SERVICE			17
19	NONPHYSICIAN ANESTHETISTS			19
20	NURSING SCHOOL			20
21	I&R SERVICES-SALARY & FRINGES APPRVD	100		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		100	22
23	PARAMED ED PRGM-(SPECIFY)			23
	INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS			30
31	INTENSIVE CARE UNIT			31
43	NURSERY			43
44	SKILLED NURSING FACILITY			44
45	NURSING FACILITY			45
	ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM			50
52	DELIVERY ROOM & LABOR ROOM			52
54	RADIOLOGY-DIAGNOSTIC			54
55	RADIOLOGY-THERAPEUTIC			55
57	CT SCAN			57
58	MRI			58
59	CARDIAC CATHETERIZATION			59
60	LABORATORY			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65	RESPIRATORY THERAPY			65
66	PHYSICAL THERAPY			66
68	SPEECH PATHOLOGY			68
69	ELECTROCARDIOLOGY			69
70	ELECTROENCEPHALOGRAPHY			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			71
72	IMPL. DEV. CHARGED TO PATIENTS			72
73	DRUGS CHARGED TO PATIENTS			73
74	RENAL DIALYSIS			74
76.97	CARDIAC REHABILITATION			76.97
76.98	HYPERBARIC OXYGEN THERAPY			76.98
76.99	LITHOTRIPSY			76.99
	OUTPATIENT SERVICE COST CENTERS			
90.01	OP PEDS ONC CLINIC			90.01
90.02	WOUND CLINIC			90.02
91	EMERGENCY	100	100	91
92	OBSERVATION BEDS (NON-DISTINCT PART)			92
92.01	OBSERVATION BEDS-DISTINCT			92.01
	OTHER REIMBURSABLE COST CENTERS			
94	HOME PROGRAM DIALYSIS			94
101	HOME HEALTH AGENCY			101
	SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	100	100	118
	NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
192	PHYSICIANS' PRIVATE OFFICES			192
194	HEALTH & FITNESS CENTER			194
194.01	OCCUPATIONAL HEALTH			194.01

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R PROGRAM COSTS ASSIGNED TIME 22	
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	104,471	19,840	202
203	UNIT COST MULT-WS B PT I	1,044.710000	198.400000	203
204	COST TO BE ALLOC PER B PT II	922	82	204
205	UNIT COST MULT-WS B PT II	9.220000	0.820000	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	29,460,674		29,460,674		29,460,674	30
31	INTENSIVE CARE UNIT	4,849,859		4,849,859		4,849,859	31
43	NURSERY	3,113,107		3,113,107		3,113,107	43
44	SKILLED NURSING FACILITY	6,647,273		6,647,273		6,647,273	44
45	NURSING FACILITY	6,895,081		6,895,081		6,895,081	45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	24,344,332		24,344,332		24,344,332	50
52	DELIVERY ROOM & LABOR ROOM	6,982,547		6,982,547		6,982,547	52
54	RADIOLOGY-DIAGNOSTIC	20,030,783		20,030,783		20,030,783	54
55	RADIOLOGY-THERAPEUTIC	3,884,286		3,884,286		3,884,286	55
57	CT SCAN	1,946,365		1,946,365		1,946,365	57
58	MRI	4,349,395		4,349,395		4,349,395	58
59	CARDIAC CATHETERIZATION	1,960,899		1,960,899		1,960,899	59
60	LABORATORY	13,769,362		13,769,362		13,769,362	60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	1,767,400		1,767,400		1,767,400	65
66	PHYSICAL THERAPY	7,038,792		7,038,792		7,038,792	66
68	SPEECH PATHOLOGY	2,522,756		2,522,756		2,522,756	68
69	ELECTROCARDIOLOGY	1,386,868		1,386,868		1,386,868	69
70	ELECTROENCEPHALOGRAPHY	684,223		684,223		684,223	70
71	MEDICAL SUPPLIES CHARGED TO	9,778,896		9,778,896		9,778,896	71
72	IMPL. DEV. CHARGED TO PATIE	9,522,116		9,522,116		9,522,116	72
73	DRUGS CHARGED TO PATIENTS	11,996,513		11,996,513		11,996,513	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	932,975		932,975		932,975	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	1,573,907		1,573,907		1,573,907	90.01
90.02	WOUND CLINIC	1,454,296		1,454,296	17,851	1,472,147	90.02
91	EMERGENCY	13,703,043		13,703,043	42,349	13,745,392	91
92	OBSERVATION BEDS (NON-DISTI	3,283,080		3,283,080		3,283,080	92
92.01	OBSERVATION BEDS-DISTINCT	16,114		16,114		16,114	92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY	3,753,794		3,753,794		3,753,794	101
200	SUBTOTAL (SEE INSTRUCTIONS)	197,648,736		197,648,736	60,200	197,708,936	200
201	LESS OBSERVATION BEDS	3,283,080		3,283,080		3,283,080	201
202	TOTAL (SEE INSTRUCTIONS)	194,365,656		194,365,656		194,425,856	202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	48,376,065		48,376,065				30
31	INTENSIVE CARE UNIT	9,705,370		9,705,370				31
43	NURSERY	6,402,243		6,402,243				43
44	SKILLED NURSING FACILITY	9,055,000		9,055,000				44
45	NURSING FACILITY	2,780,670		2,780,670				45
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	19,682,349	59,758,815	79,441,164	0.306445	0.306445	0.306445	50
52	DELIVERY ROOM & LABOR ROOM	10,191,555	915,316	11,106,871	0.628669	0.628669	0.628669	52
54	RADIOLOGY-DIAGNOSTIC	11,530,766	86,477,147	98,007,913	0.204379	0.204379	0.204379	54
55	RADIOLOGY-THERAPEUTIC	243,036	19,821,543	20,064,579	0.193589	0.193589	0.193589	55
57	CT SCAN	11,449,381	25,921,169	37,370,550	0.052083	0.052083	0.052083	57
58	MRI	7,846,616	52,793,254	60,639,870	0.071725	0.071725	0.071725	58
59	CARDIAC CATHETERIZATION	5,623,384	3,495,952	9,119,336	0.215027	0.215027	0.215027	59
60	LABORATORY	35,180,268	44,821,476	80,001,744	0.172113	0.172113	0.172113	60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	5,888,784	1,010,315	6,899,099	0.256178	0.256178	0.256178	65
66	PHYSICAL THERAPY	8,941,762	8,218,282	17,160,044	0.410185	0.410185	0.410185	66
68	SPEECH PATHOLOGY	846,359	3,442,403	4,288,762	0.588225	0.588225	0.588225	68
69	ELECTROCARDIOLOGY	7,209,265	15,687,401	22,896,666	0.060571	0.060571	0.060571	69
70	ELECTROENCEPHALOGRAPHY	174,325	674,808	849,133	0.805790	0.805790	0.805790	70
71	MEDICAL SUPPLIES CHARGED TO	17,114,886	19,049,815	36,164,701	0.270399	0.270399	0.270399	71
72	IMPL. DEV. CHARGED TO PATIE	11,968,335	4,924,363	16,892,698	0.563682	0.563682	0.563682	72
73	DRUGS CHARGED TO PATIENTS	19,259,576	31,102,645	50,362,221	0.238205	0.238205	0.238205	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	1,478	1,403,300	1,404,778	0.664144	0.664144	0.664144	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC	87,349	3,056,928	3,144,277	0.500562	0.500562	0.500562	90.01
90.02	WOUND CLINIC	114,575	2,131,764	2,246,339	0.647407	0.647407	0.655354	90.02
91	EMERGENCY	14,386,808	70,299,600	84,686,408	0.161809	0.161809	0.162309	91
92	OBSERVATION BEDS (NON-DISTI	584,957	5,883,799	6,468,756	0.507529	0.507529	0.507529	92
92.01	OBSERVATION BEDS-DISTINCT	6,718	502,570	509,288	0.031640	0.031640	0.031640	92.01
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
101	HOME HEALTH AGENCY		5,961,600	5,961,600				101
200	SUBTOTAL (SEE INSTRUCTIONS)	264,651,880	467,354,265	732,006,145				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	264,651,880	467,354,265	732,006,145				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	939,515		939,515	24,049	39.07	8,690	339,518	30
31	INTENSIVE CARE UNIT	131,714		131,714	2,213	59.52	1,002	59,639	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	33,568		33,568	1,230	27.29			43
44	SKILLED NURSING FACILITY	316,531		316,531	9,055	34.96	7,218	252,341	44
45	NURSING FACILITY	793,680		793,680					45
200	TOTAL (LINES 30-199)	2,215,008		2,215,008	36,547		16,910	651,498	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES [ ] TITLE V [XX] TITLE XVIII-PT A [ ] TITLE XIX [XX] HOSPITAL (14-0130) [ ] IPF [ ] IRF [ ] SUB (OTHER) [XX] PPS [ ] TEFRA

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,533,454	79,441,164	0.031891	7,893,303	251,725	50
52	DELIVERY ROOM & LABOR ROOM	226,274	11,106,871	0.020372			52
54	RADIOLOGY-DIAGNOSTIC	2,425,465	98,007,913	0.024748	5,633,176	139,410	54
55	RADIOLOGY-THERAPEUTIC	1,313,124	20,064,579	0.065445	196,321	12,848	55
57	CT SCAN	40,008	37,370,550	0.001071	5,351,018	5,731	57
58	MRI	854,584	60,639,870	0.014093	2,683,829	37,823	58
59	CARDIAC CATHETERIZATION	171,476	9,119,336	0.018804	2,590,481	48,711	59
60	LABORATORY	534,168	80,001,744	0.006677	14,397,580	96,133	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	19,346	6,899,099	0.002804	2,878,734	8,072	65
66	PHYSICAL THERAPY	320,800	17,160,044	0.018695	1,810,092	33,840	66
68	SPEECH PATHOLOGY	210,247	4,288,762	0.049023	211,614	10,374	68
69	ELECTROCARDIOLOGY	177,988	22,896,666	0.007774	3,490,086	27,132	69
70	ELECTROENCEPHALOGRAPHY	64,201	849,133	0.075608	80,981	6,123	70
71	MEDICAL SUPPLIES CHARGED TO P	40,298	36,164,701	0.001114	6,443,723	7,178	71
72	IMPL. DEV. CHARGED TO PATIENT	39,240	16,892,698	0.002323	5,738,123	13,330	72
73	DRUGS CHARGED TO PATIENTS	49,437	50,362,221	0.000982	7,015,922	6,890	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	60,396	1,404,778	0.042993			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	114,371	3,144,277	0.036374	46,626	1,696	90.01
90.02	WOUND CLINIC	44,659	2,246,339	0.019881	57,742	1,148	90.02
91	EMERGENCY	486,922	84,686,408	0.005750	5,949,244	34,208	91
92	OBSERVATION BEDS (NON-DISTINC	104,697	6,468,756	0.016185			92
92.01	OBSERVATION BEDS-DISTINCT	4,521	509,288	0.008877	1,309	12	92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	9,835,676	649,725,197		72,469,904	742,384	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	24,049		8,690		30
31	INTENSIVE CARE UNIT	2,213		1,002		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	1,230				43
44	SKILLED NURSING FACILITY	9,055		7,218		44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	36,547		16,910		200

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

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-0130)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	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 (14-0130) [ ] 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	79,441,164			7,893,303		13,263,706		50
52	DELIVERY ROOM & LABOR ROOM	11,106,871					615		52
54	RADIOLOGY-DIAGNOSTIC	98,007,913			5,633,176		17,904,308		54
55	RADIOLOGY-THERAPEUTIC	20,064,579			196,321		9,405,412		55
57	CT SCAN	37,370,550			5,351,018		7,919,983		57
58	MRI	60,639,870			2,683,829		12,928,691		58
59	CARDIAC CATHETERIZATION	9,119,336			2,590,481		1,772,560		59
60	LABORATORY	80,001,744			14,397,580		3,197,857		60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	6,899,099			2,878,734		288,736		65
66	PHYSICAL THERAPY	17,160,044			1,810,092		123		66
68	SPEECH PATHOLOGY	4,288,762			211,614		451,640		68
69	ELECTROCARDIOLOGY	22,896,666			3,490,086		4,419,356		69
70	ELECTROENCEPHALOGRAPHY	849,133			80,981		142,169		70
71	MEDICAL SUPPLIES CHARGED TO	36,164,701			6,443,723		4,107,367		71
72	IMPL. DEV. CHARGED TO PATIEN	16,892,698			5,738,123		1,336,427		72
73	DRUGS CHARGED TO PATIENTS	50,362,221			7,015,922		9,826,681		73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1,404,778					912,414		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	3,144,277			46,626		1,323,567		90.01
90.02	WOUND CLINIC	2,246,339			57,742		1,473,033		90.02
91	EMERGENCY	84,686,408			5,949,244		8,642,260		91
92	OBSERVATION BEDS (NON-DISTIN	6,468,756							92
92.01	OBSERVATION BEDS-DISTINCT	509,288			1,309		17,735		92.01
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	649,725,197			72,469,904		99,334,640		200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0130)	[ ]	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	0.306445	13,263,706	1		4,064,596			50
52	DELIVERY ROOM & LABOR ROOM	0.628669	615			387			52
54	RADIOLOGY-DIAGNOSTIC	0.204379	17,904,308			3,659,265			54
55	RADIOLOGY-THERAPEUTIC	0.193589	9,405,412			1,820,784			55
57	CT SCAN	0.052083	7,919,983			412,496			57
58	MRI	0.071725	12,928,691			927,310			58
59	CARDIAC CATHETERIZATION	0.215027	1,772,560			381,148			59
60	LABORATORY	0.172113	3,197,857	3,046		550,393	524		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.256178	288,736	1		73,968			65
66	PHYSICAL THERAPY	0.410185	123			50			66
68	SPEECH PATHOLOGY	0.588225	451,640			265,666			68
69	ELECTROCARDIOLOGY	0.060571	4,419,356			267,685			69
70	ELECTROENCEPHALOGRAPHY	0.805790	142,169			114,558			70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399	4,107,367			1,110,628			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682	1,336,427			753,320			72
73	DRUGS CHARGED TO PATIENTS	0.238205	9,826,681	19,075		2,340,765	4,544		73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	0.664144	912,414			605,974			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.500562	1,323,567	53		662,527	27		90.01
90.02	WOUND CLINIC	0.647407	1,473,033			953,652			90.02
91	EMERGENCY	0.161809	8,642,260	3,815		1,398,395	617		91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529							92
92.01	OBSERVATION BEDS-DISTINCT	0.031640	17,735			561			92.01
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)		99,334,640	25,991		20,364,128	5,712		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)		99,334,640	25,991		20,364,128	5,712		202

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	[ ]	IPF	[XX]	SNF (14-5216)			[ ]	TEFRA
BOXES	[ ] TITLE XIX	[ ]	IRF	[ ]	NF				

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	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	[ ] HOSPITAL	[ ] SUB (OTHER)	[ ] ICF/MR	[XX] PPS
	[XX] TITLE XVIII-PT A	[ ] IPF	[XX] SNF (14-5216)		[ ] TEFRA
	[ ] TITLE XIX	[ ] IRF	[ ] NF		

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	79,441,164							50
52	DELIVERY ROOM & LABOR ROOM	11,106,871							52
54	RADIOLOGY-DIAGNOSTIC	98,007,913							54
55	RADIOLOGY-THERAPEUTIC	20,064,579							55
57	CT SCAN	37,370,550							57
58	MRI	60,639,870							58
59	CARDIAC CATHETERIZATION	9,119,336							59
60	LABORATORY	80,001,744							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	6,899,099							65
66	PHYSICAL THERAPY	17,160,044							66
68	SPEECH PATHOLOGY	4,288,762							68
69	ELECTROCARDIOLOGY	22,896,666							69
70	ELECTROENCEPHALOGRAPHY	849,133							70
71	MEDICAL SUPPLIES CHARGED TO	36,164,701							71
72	IMPL. DEV. CHARGED TO PATIEN	16,892,698							72
73	DRUGS CHARGED TO PATIENTS	50,362,221							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1,404,778							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	3,144,277							90.01
90.02	WOUND CLINIC	2,246,339							90.02
91	EMERGENCY	84,686,408							91
92	OBSERVATION BEDS (NON-DISTIN	6,468,756							92
92.01	OBSERVATION BEDS-DISTINCT	509,288							92.01
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	649,725,197							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	[ ]	IPF	[XX]	SNF (14-5216)	[ ]	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	0.306445							50
52	DELIVERY ROOM & LABOR ROOM	0.628669							52
54	RADIOLOGY-DIAGNOSTIC	0.204379							54
55	RADIOLOGY-THERAPEUTIC	0.193589							55
57	CT SCAN	0.052083							57
58	MRI	0.071725							58
59	CARDIAC CATHETERIZATION	0.215027							59
60	LABORATORY	0.172113							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.256178							65
66	PHYSICAL THERAPY	0.410185							66
68	SPEECH PATHOLOGY	0.588225							68
69	ELECTROCARDIOLOGY	0.060571							69
70	ELECTROENCEPHALOGRAPHY	0.805790							70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682							72
73	DRUGS CHARGED TO PATIENTS	0.238205							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	0.664144							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.500562							90.01
90.02	WOUND CLINIC	0.647407							90.02
91	EMERGENCY	0.161809							91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529							92
92.01	OBSERVATION BEDS-DISTINCT	0.031640							92.01
	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	939,515		939,515	24,049	39.07	1,142	44,618	30
31	INTENSIVE CARE UNIT	131,714		131,714	2,213	59.52	200	11,904	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	33,568		33,568	1,230	27.29	430	11,735	43
44	SKILLED NURSING FACILITY	316,531		316,531	9,055	34.96			44
45	NURSING FACILITY	793,680		793,680					45
200	TOTAL (LINES 30-199)	2,215,008		2,215,008	36,547		1,772	68,257	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0130)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF			[XX] OTHER

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,533,454	79,441,164	0.031891			50
52	DELIVERY ROOM & LABOR ROOM	226,274	11,106,871	0.020372			52
54	RADIOLOGY-DIAGNOSTIC	2,425,465	98,007,913	0.024748			54
55	RADIOLOGY-THERAPEUTIC	1,313,124	20,064,579	0.065445			55
57	CT SCAN	40,008	37,370,550	0.001071			57
58	MRI	854,584	60,639,870	0.014093			58
59	CARDIAC CATHETERIZATION	171,476	9,119,336	0.018804			59
60	LABORATORY	534,168	80,001,744	0.006677			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	19,346	6,899,099	0.002804			65
66	PHYSICAL THERAPY	320,800	17,160,044	0.018695			66
68	SPEECH PATHOLOGY	210,247	4,288,762	0.049023			68
69	ELECTROCARDIOLOGY	177,988	22,896,666	0.007774			69
70	ELECTROENCEPHALOGRAPHY	64,201	849,133	0.075608			70
71	MEDICAL SUPPLIES CHARGED TO P	40,298	36,164,701	0.001114			71
72	IMPL. DEV. CHARGED TO PATIENT	39,240	16,892,698	0.002323			72
73	DRUGS CHARGED TO PATIENTS	49,437	50,362,221	0.000982			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	60,396	1,404,778	0.042993			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC	114,371	3,144,277	0.036374			90.01
90.02	WOUND CLINIC	44,659	2,246,339	0.019881			90.02
91	EMERGENCY	486,922	84,686,408	0.005750			91
92	OBSERVATION BEDS (NON-DISTINC	104,697	6,468,756	0.016185			92
92.01	OBSERVATION BEDS-DISTINCT	4,521	509,288	0.008877			92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	9,835,676	649,725,197				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	24,049		1,142		30
31	INTENSIVE CARE UNIT	2,213		200		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	1,230		430		43
44	SKILLED NURSING FACILITY	9,055				44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	36,547		1,772		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0130)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
54	RADIOLOGY-DIAGNOSTIC							54
55	RADIOLOGY-THERAPEUTIC							55
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OP PEDS ONC CLINIC							90.01
90.02	WOUND CLINIC							90.02
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
92.01	OBSERVATION BEDS-DISTINCT							92.01
	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 (14-0130)	[ ]	SUB (OTHER)		[ ]	ICF/MR		[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF					[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF					[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	79,441,164							50
52	DELIVERY ROOM & LABOR ROOM	11,106,871							52
54	RADIOLOGY-DIAGNOSTIC	98,007,913							54
55	RADIOLOGY-THERAPEUTIC	20,064,579							55
57	CT SCAN	37,370,550							57
58	MRI	60,639,870							58
59	CARDIAC CATHETERIZATION	9,119,336							59
60	LABORATORY	80,001,744							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	6,899,099							65
66	PHYSICAL THERAPY	17,160,044							66
68	SPEECH PATHOLOGY	4,288,762							68
69	ELECTROCARDIOLOGY	22,896,666							69
70	ELECTROENCEPHALOGRAPHY	849,133							70
71	MEDICAL SUPPLIES CHARGED TO	36,164,701							71
72	IMPL. DEV. CHARGED TO PATIEN	16,892,698							72
73	DRUGS CHARGED TO PATIENTS	50,362,221							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1,404,778							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	3,144,277							90.01
90.02	WOUND CLINIC	2,246,339							90.02
91	EMERGENCY	84,686,408							91
92	OBSERVATION BEDS (NON-DISTIN	6,468,756							92
92.01	OBSERVATION BEDS-DISTINCT	509,288							92.01
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	649,725,197							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-0130)	[ ]	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	0.306445							50
52	DELIVERY ROOM & LABOR ROOM	0.628669							52
54	RADIOLOGY-DIAGNOSTIC	0.204379							54
55	RADIOLOGY-THERAPEUTIC	0.193589							55
57	CT SCAN	0.052083							57
58	MRI	0.071725							58
59	CARDIAC CATHETERIZATION	0.215027							59
60	LABORATORY	0.172113							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.256178							65
66	PHYSICAL THERAPY	0.410185							66
68	SPEECH PATHOLOGY	0.588225							68
69	ELECTROCARDIOLOGY	0.060571							69
70	ELECTROENCEPHALOGRAPHY	0.805790							70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682							72
73	DRUGS CHARGED TO PATIENTS	0.238205							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	0.664144							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OP PEDS ONC CLINIC	0.500562							90.01
90.02	WOUND CLINIC	0.647407							90.02
91	EMERGENCY	0.161809							91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529							92
92.01	OBSERVATION BEDS-DISTINCT	0.031640							92.01
	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 (14-0130)	[ ]	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)	24,049	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	24,049	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	21,369	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)	8,690	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)	29,460,674	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	29,460,674	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)	29,460,674	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] TITLE XVIII-PT A [ ] TITLE XIX-INPT; [XX] HOSPITAL (14-0130) [ ] IPF [ ] IRF; [ ] SUB (OTHER); [XX] PPS [ ] TEFRA [ ] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,225.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	10,645,511	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)	10,645,511	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	4,849,859	2,213	2,191.53	1,002	2,195,913	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)					16,670,389	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					29,511,813	49

	PASS-THROUGH COST ADJUSTMENTS		
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)	399,157	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)	742,384	51
52	TOTAL PROGRAM EXCLUDABLE COST	1,141,541	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)	28,370,272	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)	2,680	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,225.03	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	3,283,080	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	939,515	29,460,674	0.031890	3,283,080	104,697	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	[ ]	IPF	[XX]	SNF (14-5216)			[ ]	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)	9,055	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	9,055	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	9,055	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)	7,218	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)	6,647,273	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	6,647,273	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)	6,647,273	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PARTS III & IV

CHECK	[ ]	TITLE V-INPT	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[ ]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[XX]	SNF (14-5216)			[ ]	TEFRA
BOXES	[ ]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[ ]	OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	6,647,273	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	734.10	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	5,298,734	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	5,298,734	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	5,298,734	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)		84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	5,298,734	86

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-0130)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF	[ ]	NF			[XX]	OTHER

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	24,049	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	24,049	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	21,369	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)	1,142	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)	1,230	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	430	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)	29,460,674	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	29,460,674	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)	29,460,674	37

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

CHECK APPLICABLE BOXES: [ ] TITLE V-INPT [XX] HOSPITAL (14-0130) [ ] SUB (OTHER) [ ] PPS
[ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA
[XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)					1,225.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)					1,398,984	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)					1,398,984	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)	3,113,107	1,230	2,530.98	430	1,088,321	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	4,849,859	2,213	2,191.53	200	438,306	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)					2,925,611	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					68,257	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					68,257	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (LINE 54 x LINE 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT (SEE INSTRUCTIONS)						58
59	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)						61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS)					2,680	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)						88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)						89

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

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0130)	[ ]	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		20,356,679		30
31	INTENSIVE CARE UNIT		4,708,032		31
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306445	7,893,303	2,418,863	50
52	DELIVERY ROOM & LABOR ROOM	0.628669			52
54	RADIOLOGY-DIAGNOSTIC	0.204379	5,633,176	1,151,303	54
55	RADIOLOGY-THERAPEUTIC	0.193589	196,321	38,006	55
57	CT SCAN	0.052083	5,351,018	278,697	57
58	MRI	0.071725	2,683,829	192,498	58
59	CARDIAC CATHETERIZATION	0.215027	2,590,481	557,023	59
60	LABORATORY	0.172113	14,397,580	2,478,011	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.256178	2,878,734	737,468	65
66	PHYSICAL THERAPY	0.410185	1,810,092	742,473	66
68	SPEECH PATHOLOGY	0.588225	211,614	124,477	68
69	ELECTROCARDIOLOGY	0.060571	3,490,086	211,398	69
70	ELECTROENCEPHALOGRAPHY	0.805790	80,981	65,254	70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399	6,443,723	1,742,376	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682	5,738,123	3,234,477	72
73	DRUGS CHARGED TO PATIENTS	0.238205	7,015,922	1,671,228	73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	0.664144			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.500562	46,626	23,339	90.01
90.02	WOUND CLINIC	0.655354	57,742	37,841	90.02
91	EMERGENCY	0.162309	5,949,244	965,616	91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529			92
92.01	OBSERVATION BEDS-DISTINCT	0.031640	1,309	41	92.01
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		72,469,904	16,670,389	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		72,469,904		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	[ ]	IPF	[XX]	SNF (14-5216)	[ ]	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
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306445			50
52	DELIVERY ROOM & LABOR ROOM	0.628669			52
54	RADIOLOGY-DIAGNOSTIC	0.204379			54
55	RADIOLOGY-THERAPEUTIC	0.193589			55
57	CT SCAN	0.052083			57
58	MRI	0.071725			58
59	CARDIAC CATHETERIZATION	0.215027			59
60	LABORATORY	0.172113			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.256178			65
66	PHYSICAL THERAPY	0.410185			66
68	SPEECH PATHOLOGY	0.588225			68
69	ELECTROCARDIOLOGY	0.060571			69
70	ELECTROENCEPHALOGRAPHY	0.805790			70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682			72
73	DRUGS CHARGED TO PATIENTS	0.238205			73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	0.664144			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.500562			90.01
90.02	WOUND CLINIC	0.647407			90.02
91	EMERGENCY	0.161809			91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529			92
92.01	OBSERVATION BEDS-DISTINCT	0.031640			92.01
	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	[XX]	HOSPITAL (14-0130)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.306445			50
52	DELIVERY ROOM & LABOR ROOM	0.628669			52
54	RADIOLOGY-DIAGNOSTIC	0.204379			54
55	RADIOLOGY-THERAPEUTIC	0.193589			55
57	CT SCAN	0.052083			57
58	MRI	0.071725			58
59	CARDIAC CATHETERIZATION	0.215027			59
60	LABORATORY	0.172113			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.256178			65
66	PHYSICAL THERAPY	0.410185			66
68	SPEECH PATHOLOGY	0.588225			68
69	ELECTROCARDIOLOGY	0.060571			69
70	ELECTROENCEPHALOGRAPHY	0.805790			70
71	MEDICAL SUPPLIES CHARGED TO PAT	0.270399			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.563682			72
73	DRUGS CHARGED TO PATIENTS	0.238205			73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	0.664144			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OP PEDS ONC CLINIC	0.500562			90.01
90.02	WOUND CLINIC	0.647407			90.02
91	EMERGENCY	0.161809			91
92	OBSERVATION BEDS (NON-DISTINCT	0.507529			92
92.01	OBSERVATION BEDS-DISTINCT	0.031640			92.01
	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 (14-0130)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	19,292,827	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	809,146	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	109.66	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (SEE INSTRUCTIONS)		31
32	SUM OF LINES 30 AND 31		32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		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)	20,101,973	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)	20,101,973	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,598,408	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 (14-0130)
APPLICABLE BOX: [ ] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	21,700,381	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	21,700,381	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	2,257,811	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	16,147	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	162,649	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	113,854	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	123,386	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	19,540,277	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)	-38,827	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	36,520	70.94
71	AMOUNT DUE PROVIDER (SEE INSTRUCTIONS)	19,537,970	71
71.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	164,119	71.01
72	INTERIM PAYMENTS	19,264,307	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS LINES 71.01, 72 AND 73)	109,544	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2		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 (14-0130) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,712	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	20,364,128	2
3	PPS PAYMENTS	15,710,602	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	62,012	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)	5,712	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	25,991	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)	25,991	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)	25,991	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS)	20,279	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)	5,712	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)	15,772,614	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	3,673,014	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	12,105,312	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)	12,105,312	30
31	PRIMARY PAYER PAYMENTS		31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	12,105,312	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)	191,499	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	134,049	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	167,285	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	12,239,361	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	12,239,361	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	102,811	40.01
41	INTERIM PAYMENTS	11,989,210	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	147,340	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 [ ] IPF [ ] IRF
[ ] SUB (OTHER) [XX] SNF (14-5216)

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 (14-0130) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	INPATIENT PART B MM/DD/YYYY 3	INPATIENT PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER							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.				19,264,307		11,989,210	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
			.02					3.02
		PROGRAM	.03					3.03
		TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				19,264,307		11,989,210	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01		273,663		250,151	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				19,537,970		12,239,361	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 (14-0130) [ ] 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	7,947	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	9,692	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	331	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	23,582	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	732,006,145	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	32,577,068	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,120,763	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)	22,415	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)	1,098,348	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,145,670	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)	-47,322	32

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT	
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS	2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS	3
4	SUBTOTAL (SUM OF LINES 1-3)	4
	COMPUTATION OF NET COST OF COVERED SERVICES	
5	MEDICAL AND OTHER SERVICES	5
6	DEDUCTIBLES	6
7	COINSURANCE	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	9
10	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	10
11	UTILIZATION REVIEW	11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	12
13	INPATIENT PRIMARY PAYER PAYMENTS	13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	15
15.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	15.01
16	INTERIM PAYMENTS	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS 15.01, 16 AND 17)	18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	19

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-0130)	[ ]	SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
BOXES:			[ ]	IRF	[ ]	ICF/MR	[XX]	OTHER
			[ ]	SUB (OTHER)				

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

		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	2,925,611		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	2,925,611		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	2,925,611		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)	2,925,611		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				1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			0.87	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)			0.87	5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			0.87	6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			0.87	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		0.87		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				16
17	ADJUSTED ROLLING AVERAGE FTE COUNT		0.87		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	9,692	331		26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	23,582	23,582		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.410991	0.014036		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)			34,810,547	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)			34,810,547	41
	PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			20,369,840	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)				43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			20,369,840	44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			55,180,387	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.630850	46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.369150	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

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	1,342	242		26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	23,582	23,582		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.056908	0.010262		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	27,376,193				1
2	TEMPORARY INVESTMENTS	27,049				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	81,988,940				4
5	OTHER RECEIVABLES	230,542	35,434			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-58,408,344				6
7	INVENTORY	4,972,323				7
8	PREPAID EXPENSES	223,497				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	56,410,200	35,434			11
	FIXED ASSETS					
12	LAND	55,533,262				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	186,196,256				15
16	ACCUMULATED DEPRECIATION	-51,609,664				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	33,014,795				19
20	ACCUMULATED DEPRECIATION	-18,239,088				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)	204,895,561				30
	OTHER ASSETS					
31	INVESTMENTS	123,919,571	3,998,757	25,176,543		31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	35,565,067				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	159,484,638	3,998,757	25,176,543		35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	420,790,399	4,034,191	25,176,543		36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	16,813,333				37
38	SALARIES, WAGES & FEES PAYABLE	12,232,818				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	2,830,000				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	33,494,765				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	65,370,916				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	62,113,700				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	21,617,984				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	83,731,684				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	149,102,600				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	271,687,799				52
53	SPECIFIC PURPOSE FUND BALANCE		4,034,191			53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			25,176,543		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)	271,687,799	4,034,191	25,176,543		59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	420,790,399	4,034,191	25,176,543		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	243,727,827		3,971,024		25,176,543				1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	8,659,328								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	252,387,155		3,971,024		25,176,543				3
4	ADDITIONS (CREDIT ADJUST-MENTS)	19,300,643								4
5	ASSETS RELEASED FROM RESTRICTIONS									5
6	GIFTS, GRANTS & OTHER REVENUE			652,537						6
7	INVESTMENT INCOME - REALIZED GAIN			327,302						7
8	UNREALIZED GAINS (LOSSES)									8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)	19,300,643		979,839						10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	271,687,798		4,950,863		25,176,543				11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	OPERATING EXPENSES			431,997						13
14	PROPERTY ADDITIONS			494,438						14
15	CHNG IN VALUE OF SPLIT INT AGREEM			237						15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)			926,672						18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	271,687,798		4,024,191		25,176,543				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	46,321,224		46,321,224	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	9,055,000		9,055,000	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	55,376,224		55,376,224	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT	9,524,414		9,524,414	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)	9,524,414		9,524,414	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	64,900,638		64,900,638	17
18	ANCILLARY SERVICES	197,862,561	478,602,669	676,465,230	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		5,961,600	5,961,600	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER PATIENT REVENUES	4,468,319	26,774,520	31,242,839	27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	267,231,518	511,338,789	778,570,307	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		233,106,479	29
30	ADD (SPECIFY)			30
31	BAD DEBT			31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		233,106,479	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	778,570,307	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	571,349,816	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	207,220,491	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	233,106,479	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-25,885,988	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	9,482,170	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	1,067,282	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	57,589	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	5,859,349	22
23	GOVERNMENTAL APPROPRIATIONS	1,985,315	23
24	OTHER (SHARED TELECOM OTHER)	2,051,753	24
24.01	OTHER (OTHER INCOME)	14,041,858	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	34,545,316	25
26	TOTAL (LINE 5 PLUS LINE 25)	8,659,328	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	8,659,328	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7045 WORKSHEET H

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTRUCTIONS)							4
5	ADMINISTRATIVE AND GENERAL							5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	1,456,959	546,990				2,003,949	6
7	PHYSICAL THERAPY	795,292	298,579				1,093,871	7
8	OCCUPATIONAL THERAPY	74,759	28,067				102,826	8
9	SPEECH PATHOLOGY	35,463	13,314				48,777	9
10	MEDICAL SOCIAL SERVICES	50,580	18,989				69,569	10
11	HOME HEALTH AIDE	56,978	21,391				78,369	11
12	SUPPLIES (SEE INSTRUCTIONS)	24,414	9,166				33,580	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
24	TOTAL (SUM OF LINES 1-23)	2,494,445	936,496				3,430,941	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7045 WORKSHEET H (CONTINUED)

		RECLASS-IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (SEE INSTRUCTIONS)					4
5	ADMINISTRATIVE AND GENERAL					5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE	19,140	2,023,089	-881,762	1,141,327	6
7	PHYSICAL THERAPY	10,449	1,104,320	-481,316	623,004	7
8	OCCUPATIONAL THERAPY	982	103,808	-45,245	58,563	8
9	SPEECH PATHOLOGY	466	49,243	-21,463	27,780	9
10	MEDICAL SOCIAL SERVICES	665	70,234	-30,611	39,623	10
11	HOME HEALTH AIDE	749	79,118	-34,484	44,634	11
12	SUPPLIES (SEE INSTRUCTIONS)	321	33,901	-14,775	19,126	12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
24	TOTAL (SUM OF LINES 1-23)	32,772	3,463,713	-1,509,656	1,954,057	24

COST ALLOCATION - HHA GENERAL SERVICE COST HHA NO.: 14-7045 WORKSHEET H-1 PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL COSTS BLDG & FIXTURES 1	CAP REL COSTS MVBL EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDGS & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION (SEE INSTR.)									4
5	ADMINISTRATIVE AND GENERAL									5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	1,141,327					1,141,327		1,141,327	6
7	PHYSICAL THERAPY	623,004					623,004		623,004	7
8	OCCUPATIONAL THERAPY	58,563					58,563		58,563	8
9	SPEECH PATHOLOGY	27,780					27,780		27,780	9
10	MEDICAL SOCIAL SERVICES	39,623					39,623		39,623	10
11	HOME HEALTH AIDE	44,634					44,634		44,634	11
12	SUPPLIES (SEE INSTRUCTIONS)	19,126					19,126		19,126	12
13	DRUGS									13
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING									17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
24	TOTAL (SUM OF LINES 1-23)	1,954,057					1,954,057		1,954,057	24

COST ALLOCATION - HHA STATISTICAL BASIS HHA NO.: 14-7045 WORKSHEET H-1
PART II

		CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDGS & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (SEE INSTR.)							4
5	ADMINISTRATIVE AND GENERAL						1,954,057	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						1,141,327	6
7	PHYSICAL THERAPY						623,004	7
8	OCCUPATIONAL THERAPY						58,563	8
9	SPEECH PATHOLOGY						27,780	9
10	MEDICAL SOCIAL SERVICES						39,623	10
11	HOME HEALTH AIDE						44,634	11
12	SUPPLIES (SEE INSTRUCTIONS)						19,126	12
13	DRUGS							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (SUM OF LINES 1-23)						1,954,057	24
25	COST TO BE ALLOC (PER W/S H)							25
26	UNIT COST MULTIPLIER							26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
PART I

	HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS DEPARTMENT 4	SUBTOTAL (COLS.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5	MAIN-TENANCE & REPAIRS 6	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE	1,141,327	31,967			259,435	1,432,729	597,682		2
3	PHYSICAL THERAPY	623,004	17,450			141,614	782,068	326,251		3
4	OCCUPATIONAL THERAPY	58,563	1,640			13,312	73,515	30,668		4
5	SPEECH PATHOLOGY	27,780	778			6,315	34,873	14,548		5
6	MEDICAL SOCIAL SERVICES	39,623	1,110			9,007	49,740	20,750		6
7	HOME HEALTH AIDE	44,634	1,250			10,146	56,030	23,374		7
8	SUPPLIES	19,126	535			4,347	24,008	10,015		8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	1,954,057	54,730			444,176	2,452,963	1,023,288		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
PART I

	HHA COST CENTER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		7	8	9	10	11	12	13	14	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE	2,314				28,944		122,263		2
3	PHYSICAL THERAPY	1,274				15,806		66,619		3
4	OCCUPATIONAL THERAPY	142				1,486		6,337		4
5	SPEECH PATHOLOGY	47				703		2,937		5
6	MEDICAL SOCIAL SERVICES	94				1,007		4,173		6
7	HOME HEALTH AIDE	94				1,135		4,792		7
8	SUPPLIES					479		2,009		8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	3,965				49,560		209,130		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
PART I

	HHA COST CENTER	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	
		15	16	17	19	20	21	22	23	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE	295	8,401							2
3	PHYSICAL THERAPY	160	4,586							3
4	OCCUPATIONAL THERAPY	15	431							4
5	SPEECH PATHOLOGY	7	205							5
6	MEDICAL SOCIAL SERVICES	10	292							6
7	HOME HEALTH AIDE	11	329							7
8	SUPPLIES	5	141							8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
20	TOTAL (SUM OF LINES 1-19)	503	14,385							20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
PART I

	HHA COST CENTER	SUBTOTAL (SUM OF COL.4A-23) 24	I&R COST & POST STEP-DOWN ADJS 25	SUBTOTAL (SUM OF COL.4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1	ADMINISTRATIVE AND GENERAL						1
2	SKILLED NURSING CARE	2,192,628		2,192,628	2,192,628		2
3	PHYSICAL THERAPY	1,196,764		1,196,764	1,196,764		3
4	OCCUPATIONAL THERAPY	112,594		112,594	112,594		4
5	SPEECH PATHOLOGY	53,320		53,320	53,320		5
6	MEDICAL SOCIAL SERVICES	76,066		76,066	76,066		6
7	HOME HEALTH AIDE	85,765		85,765	85,765		7
8	SUPPLIES	36,657		36,657	36,657		8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTAL (SUM OF LINES 1-19)	3,753,794		3,753,794	3,753,794		20
21	UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.						21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	OTHER CAP REL COSTS NOT USED 3	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	RECON-CILIATION 4A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	MAIN-TENANCE & REPAIRS SQUARE FEET 6	OPERATION OF PLANT SQUARE FEET 7	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE	31,770			1,456,958		1,432,729		49	2
3	PHYSICAL THERAPY	17,342			795,292		782,068		27	3
4	OCCUPATIONAL THERAPY	1,630			74,759		73,515		3	4
5	SPEECH PATHOLOGY	773			35,463		34,873		1	5
6	MEDICAL SOCIAL SERVICES	1,103			50,580		49,740		2	6
7	HOME HEALTH AIDE	1,242			56,978		56,030		2	7
8	SUPPLIES	532			24,414		24,008			8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)	54,392			2,494,444		2,452,963		84	20
21	TOTAL COST TO BE ALLOCATED	54,730			444,176		1,023,288		3,965	21
22	UNIT COST MULTIPLIER	1.006214								22
22	UNIT COST MULTIPLIER				0.178066		0.417164		47.202381	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA MEALS SERVED 11	MAINTENANCE OF PERSONNEL NUMBER HOUSED 12	NURSING ADMINISTRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	
1	ADMINISTRATIVE AND GENERAL									1
2	SKILLED NURSING CARE				1,811		791		5,113	2
3	PHYSICAL THERAPY				989		431		2,791	3
4	OCCUPATIONAL THERAPY				93		41		262	4
5	SPEECH PATHOLOGY				44		19		124	5
6	MEDICAL SOCIAL SERVICES				63		27		177	6
7	HOME HEALTH AIDE				71		31		200	7
8	SUPPLIES				30		13		86	8
9	DRUGS									9
10	DME									10
11	HOME DIALYSIS AIDE SERVICES									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIES									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGRAM									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTAL (SUM OF LINES 1-19)				3,101		1,353		8,753	20
21	TOTAL COST TO BE ALLOCATED				49,560		209,130		503	21
22	UNIT COST MULTIPLIER									22
22	UNIT COST MULTIPLIER				15.981941		154.567627		0.057466	22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7045 WORKSHEET H-2
STATISTICAL BASIS PART II

	HHA COST CENTER	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	NONPHYSIC. ANESTHET. ASSIGNED TIME 19	NURSING SCHOOL ASSIGNED TIME 20	I&R SALARY & FRINGES ASSIGNED TIME 21	I&R PROGRAM COSTS ASSIGNED TIME 22	PARAMED EDUCATION ASSIGNED TIME 23	
1	ADMINISTRATIVE AND GENERAL								1
2	SKILLED NURSING CARE	3,482,061							2
3	PHYSICAL THERAPY	1,900,709							3
4	OCCUPATIONAL THERAPY	178,670							4
5	SPEECH PATHOLOGY	84,756							5
6	MEDICAL SOCIAL SERVICES	120,883							6
7	HOME HEALTH AIDE	136,175							7
8	SUPPLIES	58,347							8
9	DRUGS								9
10	DME								10
11	HOME DIALYSIS AIDE SERVICES								11
12	RESPIRATORY THERAPY								12
13	PRIVATE DUTY NURSING								13
14	CLINIC								14
15	HEALTH PROMOTION ACTIVITIES								15
16	DAY CARE PROGRAM								16
17	HOME DELIVERED MEALS PROGRAM								17
18	HOMEMAKER SERVICE								18
19	ALL OTHERS								19
19.50	TELEMEDICINE								19.50
20	TOTAL (SUM OF LINES 1-19)	5,961,601							20
21	TOTAL COST TO BE ALLOCATED	14,385							21
22	UNIT COST MULTIPLIER	0.002413							22
22	UNIT COST MULTIPLIER								22

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7045 WORKSHEET H-3
PARTS I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL VISITS 4	AVERAGE COST PER VISIT (COL.3 ÷ COL.4) 5	
1	SKILLED NURSING CARE	2	2,192,628		2,192,628	4,358	503.13	1
2	PHYSICAL THERAPY	3	1,196,764		1,196,764	2,842	421.10	2
3	OCCUPATIONAL THERAPY	4	112,594		112,594	86	1,309.23	3
4	SPEECH PATHOLOGY	5	53,320		53,320	35	1,523.43	4
5	MEDICAL SOCIAL SERVICES	6	76,066		76,066	117	650.14	5
6	HOME HEALTH AIDE	7	85,765		85,765	612	140.14	6
7	TOTAL (SUM OF LINES 1-6)		3,717,137		3,717,137	8,050		7

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

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-2, PART I, COL 28, LINE	FACILITY COSTS (FROM WKST H-2, PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS COLS. 1+2) 3	TOTAL CHARGES (FROM HHA RECORD) 4	RATIO (COL.3 ÷ COL.4) 5	
15	COST OF MEDICAL SUPPLIES	8	36,657		36,657			15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7045 WORKSHEET H-3
PARTS I & II
(CONTINUED)

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS		COST OF SERVICES			
	PART B		PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL PROGRAM COST (SUM OF COLS.9-10)	
	6	7	8	9	10	11	12	
1 SKILLED NURSING CARE	2,990	1,368		1,504,359	688,282		2,192,641	1
2 PHYSICAL THERAPY	2,184	658		919,682	277,084		1,196,766	2
3 OCCUPATIONAL THERAPY	74	12		96,883	15,711		112,594	3
4 SPEECH PATHOLOGY	35			53,320			53,320	4
5 MEDICAL SOCIAL SERVICES	79	38		51,361	24,705		76,066	5
6 HOME HEALTH AIDE	270	342		37,838	47,928		85,766	6
7 TOTAL (SUM OF LINES 1-6)	5,632	2,418		2,663,443	1,053,710		3,717,153	7

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS			
		PART A	PART B NOT SUBJ TO DEDUCTIBLES & COINSUR	PART B SUBJECT TO DEDUCTIBLES & COINSUR	
	1	2	3	4	
8 SKILLED NURSING CARE	16974	219	30		8
8.01 SKILLED NURSING CARE	29404	2,771	1,338		8.01
9 PHYSICAL THERAPY	16974	85	10		9
9.01 PHYSICAL THERAPY	29404	2,099	648		9.01
10 OCCUPATIONAL THERAPY	16974				10
10.01 OCCUPATIONAL THERAPY	29404	74	12		10.01
11 SPEECH PATHOLOGY	16974				11
11.01 SPEECH PATHOLOGY	29404	35			11.01
12 MEDICAL SOCIAL SERVICES	16974	2			12
12.01 MEDICAL SOCIAL SERVICES	29404	77	38		12.01
13 HOME HEALTH AIDE	16974	19			13
13.01 HOME HEALTH AIDE	29404	251	342		13.01
14 TOTAL (SUM OF LINES 8-13)		5,632	2,418		14

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

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

	FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED	
	1	2	3	4		
1 PHYSICAL THERAPY	66	0.410185			COL 2, LINE 2	1
2 OCCUPATIONAL THERAPY	67				COL 2, LINE 3	2
3 SPEECH PATHOLOGY	68	0.588225			COL 2, LINE 4	3
4 MEDICAL SUPPLIES CHARGED TO PA	71	0.270399			COL 2, LINE 15	4
5 DRUGS CHARGED TO PATIENTS	73	0.238205			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT HHA NO.: 14-7045 WORKSHEET H-4
PARTS I & II

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

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

	DESCRIPTION	PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE	
		1	2	3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)				4
5	RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)				8
9	PRIMARY PAYER PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	926,335	356,772	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	26,179	9,460	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	7,647	8,537	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	13,133	1,914	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	2,859	1,072	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22	SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	976,153	377,755	22
23	EXCESS REASONABLE COST (FROM LINE 8)			23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	976,153	377,755	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26	NET COST (LINE 24 MINUS LINE 25)	976,153	377,755	26
27	REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	976,153	377,755	29
30	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	-4,907	-2,105	30
31	SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	971,246	375,650	31
31.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			31.01
32	INTERIM PAYMENTS (SEE INSTRUCTIONS)	971,246	375,650	32
33	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34	BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 31.01, 32 AND 33)			34
35	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2			35

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

HHA NO.: 14-7045

WORKSHEET H-5

	DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER							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.				971,246		375,650	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
			.02					3.02
		PROGRAM	.03					3.03
		TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.50		NONE		NONE	3.50
			.51					3.51
		PROVIDER	.52					3.52
		TO	.53					3.53
		PROGRAM	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)				971,246		375,650	4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01		NONE		NONE	5.01
		TO	.02					5.02
		PROVIDER	.03					5.03
			.04					5.04
			.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
		PROVIDER	.50		NONE		NONE	5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
			.53					5.53
			.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				971,246		375,650	7

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

CALCULATION OF CAPITAL PAYMENT WORKSHEET L

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL ((14-013)	[XX]	PPS	
	[XX]	TITLE XVIII-PT A	[ ]	SUB (OTHER)	[ ]	COST METHOD	
	[ ]	TITLE XIX					

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER	1,558,833	1
2	CAPITAL DRG OUTLIER PAYMENTS	39,575	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	65.68	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)	1,598,408	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 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES						21
22	I&R SERVICES-OTHER PRGM COSTS						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
54	RADIOLOGY-DIAGNOSTIC						54
55	RADIOLOGY-THERAPEUTIC						55
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PA						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OP PEDS ONC CLINIC						90.01
90.02	WOUND CLINIC						90.02
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
92.01	OBSERVATION BEDS-DISTINCT						92.01
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
101	HOME HEALTH AGENCY						101
	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
194	HEALTH & FITNESS CENTER						194
194.01	OCCUPATIONAL HEALTH						194.01
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