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

PART I - COST REPORT STATUS

PROVIDER USE ONLY
1. [X] ELECTRONICALLY FILED COST REPORT DATE: 11-01-2013 TIME: 09:35_____
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 HILLSBORO AREA HOSPITAL (14-1332) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XVIII HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-66,857	-311,452		56,364	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-137,077				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		-203,934	-311,452		56,364	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: 1200 E. TREMONT P.O.BOX: 1
2 CITY: HILLSBORO STATE: IL ZIP CODE: 62049 COUNTY: MONTGOMERY 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	HILLSBORO AREA HOSPITAL	14-1332	99914	1	09/06/1975	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	HILLSBORO AREA HOSPITAL	14-Z332	99914		04/01/2004	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012	TO: 06/30/2013							20
21	TYPE OF CONTROL		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.	2	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.			2				26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.			2				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							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 THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N	N	39

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

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

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

		Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N			61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)			
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)		62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)		62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS			
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N	63

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

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

		UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)				66

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

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

71 IF LINE 70 YES: 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

TITLE V AND XIX INPATIENT SERVICES		V 1	XIX 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)?	Y		105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.	Y		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.	N	N	107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108

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

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

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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:		118.01
	PREMIUMS: 28,776 PAID LOSSES: SELF INSURANCE:		
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

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

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

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

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

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	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	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.	1,180,743	168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		169

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

BED COMPLEMENT

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

		PART A		PART B		
		Y/N	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)	Y	10/01/2013	Y	10/01/2013	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		Y		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.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
	INTEREST EXPENSE		
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	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.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	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.	N	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.	Y	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.	N	35

		Y/N 1	DATE 2	
	HOME OFFICE COSTS			
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N		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: MARK	LAST NAME: DALLAS	TITLE: PARTNER	41
42	EMPLOYER: KERBER, ECK & BRAECKEL			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM		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)	30	25	9,125	30,936.00		1,033	62	1,289	1
2	HMO						11			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						1,647		1,647	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	30,936.00		2,680	62	2,936	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)		25	9,125	30,936.00		2,680	62	2,936	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS								389	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					338	24	431	1
2	HMO						1			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)			126.75			338	24	431	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			126.75						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

		AMOUNT REPORTED
	RETIREMENT COST	
1	401K EMPLOYER CONTRIBUTIONS	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5	401K/TSA PLAN ADMINISTRATION FEES	5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
	HEALTH AND INSURANCE COST	
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9	PRESCRIPTION DRUG PLAN	9
10	DENTAL, HEARING AND VISION PLAN	10
11	LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12	ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15	WORKERS' COMPENSATION INSURANCE	15
16	RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
	TAXES	
17	FICA-EMPLOYERS PORTION ONLY	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19	UNEMPLOYMENT INSURANCE	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	20
	OTHER	
21	EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22	DAY CARE COSTS AND ALLOWANCES	22
23	TUITION REIMBURSEMENT	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

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.	Y	04/01/2004	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				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				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				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				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				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

		CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 2	
SNF SERVICES				
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				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)				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)	0.463625	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	607,336	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	498,794	5
6	MEDICAID CHARGES	4,557,124	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	2,112,797	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.	1,006,667	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)	1,006,667	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	859,511	174,670	1,034,181	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	398,491	80,981	479,472	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	398,491	80,981	479,472	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)			1,968,846	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			329,708	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,639,138	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			759,945	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,239,417	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,246,084	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		775,945	775,945	-116,226	1
2	00200	CAP REL COSTS-MVBLE EQUIP		881,768	881,768	22,103	2
3	00300	OTHER CAPITAL RELATED COSTS					3
4	00400	EMPLOYEE BENEFITS	67,015	2,064,742	2,131,757		4
5.01	00592	ADMINISTRATION & ACCOUNTING	143,960	2,872,954	3,016,914		5.01
5.02	00591	GENERAL	183,226	557,363	740,589	-46,049	5.02
5.03	00571	ADMITTING	115,043	17,568	132,611		5.03
5.04	00580	PATIENT ACCOUNTING	191,164	165,021	356,185		5.04
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	206,654	385,228	591,882		7
8	00800	LAUNDRY & LINEN SERVICE	46,643	43,884	90,527		8
9	00900	HOUSEKEEPING	125,903	21,302	147,205		9
10	01000	DIETARY	137,763	127,420	265,183		10
11	01100	CAFETERIA					11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION					13
13.01	01301	UR/QUALITY IMPROVEMENT	125,433	4,287	129,720		13.01
13.02	01302	NURSING ADMINISTRATION	190,358	9,967	200,325		13.02
14	01400	CENTRAL SERVICES & SUPPLY					14
14.01	01401	PURCHASING					14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	33,179	2,302	35,481		14.02
15	01500	PHARMACY		695,957	695,957	-289,583	15
16	01600	MEDICAL RECORDS & LIBRARY	205,672	37,134	242,806		16
17	01700	SOCIAL SERVICE		642	642		17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,011,333	185,589	1,196,922	-331	30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	485,901	345,120	831,021	94,612	50
53	05300	ANESTHESIOLOGY		222,399	222,399	-147,985	53
54	05400	RADIOLOGY-DIAGNOSTIC	383,179	520,017	903,196		54
54.01	03040	ULTRA SOUND		164,796	164,796		54.01
56	05600	RADIOISOTOPE	9,047	450,503	459,550		56
60	06000	LABORATORY	424,152	599,424	1,023,576		60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	113,421	35,483	148,904	-9,956	65
65.50	06501	SLEEP LAB	44,432	53,023	97,455		65.50
66	06600	PHYSICAL THERAPY	694,913	79,044	773,957		66
67	06700	OCCUPATIONAL THERAPY	101,356	3,230	104,586		67
69	06900	ELECTROCARDIOLOGY		49,281	49,281		69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS		27,921	27,921	67,943	71
73	07300	DRUGS CHARGED TO PATIENTS				285,501	73
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
91	09100	EMERGENCY	655,270	1,535,620	2,190,890	-201	91
92	09200	OBSERVATION BEDS					92
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF					99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY					99.40
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	5,695,017	12,934,934	18,629,951	-140,172	118
		NONREIMBURSABLE COST CENTERS					
192.02	19201	ASSISTED LIVING	582,364	388,008	970,372	140,172	192.02
192.03	19202	CARDIAC REHAB	2,923	88	3,011		192.03
200		TOTAL (SUM OF LINES 118-199)	6,280,304	13,323,030	19,603,334		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	659,719	-226,423	433,296	1
2	00200	CAP REL COSTS-MVBLE EQUIP	903,871	-253,941	649,930	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	2,131,757	-1,346	2,130,411	4
5.01	00592	ADMINISTRATION & ACCOUNTING	3,016,914	-2,037,083	979,831	5.01
5.02	00591	GENERAL	694,540	-203,401	491,139	5.02
5.03	00571	ADMITTING	132,611		132,611	5.03
5.04	00580	PATIENT ACCOUNTING	356,185		356,185	5.04
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	591,882		591,882	7
8	00800	LAUNDRY & LINEN SERVICE	90,527		90,527	8
9	00900	HOUSEKEEPING	147,205		147,205	9
10	01000	DIETARY	265,183	-48,377	216,806	10
11	01100	CAFETERIA				11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION				13
13.01	01301	UR/QUALITY IMPROVEMENT	129,720		129,720	13.01
13.02	01302	NURSING ADMINISTRATION	200,325		200,325	13.02
14	01400	CENTRAL SERVICES & SUPPLY				14
14.01	01401	PURCHASING				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	35,481		35,481	14.02
15	01500	PHARMACY	406,374		406,374	15
16	01600	MEDICAL RECORDS & LIBRARY	242,806	-4,292	238,514	16
17	01700	SOCIAL SERVICE	642		642	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,196,591		1,196,591	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	925,633		925,633	50
53	05300	ANESTHESIOLOGY	74,414	-59,152	15,262	53
54	05400	RADIOLOGY-DIAGNOSTIC	903,196	-289	902,907	54
54.01	03040	ULTRA SOUND	164,796		164,796	54.01
56	05600	RADIOISOTOPE	459,550		459,550	56
60	06000	LABORATORY	1,023,576	-61,200	962,376	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	138,948		138,948	65
65.50	06501	SLEEP LAB	97,455	-7,950	89,505	65.50
66	06600	PHYSICAL THERAPY	773,957		773,957	66
67	06700	OCCUPATIONAL THERAPY	104,586		104,586	67
69	06900	ELECTROCARDIOLOGY	49,281	-24,615	24,666	69
71	07100	MEDICAL SUPPLIES CHRGED TO PATIENTS	95,864	-1,085	94,779	71
73	07300	DRUGS CHARGED TO PATIENTS	285,501		285,501	73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
91	09100	EMERGENCY	2,190,689	-877,455	1,313,234	91
92	09200	OBSERVATION BEDS				92
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	18,489,779	-3,806,609	14,683,170	118
		NONREIMBURSABLE COST CENTERS				
192.02	19201	ASSISTED LIVING	1,110,544	-1,864	1,108,680	192.02
192.03	19202	CARDIAC REHAB	3,011		3,011	192.03
200		TOTAL (SUM OF LINES 118-199)	19,603,334	-3,808,473	15,794,861	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	TO RECLASS DRUG COST FROM PHARMACY	A	DRUGS CHARGED TO PATIENTS	73		285,501	1
500	TOTAL RECLASSIFICATIONS					285,501	500
	CODE LETTER - A						
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	MEDICAL SUPPLIES CHRGED TO PA	71		1,938	1
500	TOTAL RECLASSIFICATIONS					1,938	500
	CODE LETTER - B						
1	TO RECLASS MED SUPPLY FROM OR	C	MEDICAL SUPPLIES CHRGED TO PA	71		52,089	1
500	TOTAL RECLASSIFICATIONS					52,089	500
	CODE LETTER - C						
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	MEDICAL SUPPLIES CHRGED TO PA	71		9,956	1
500	TOTAL RECLASSIFICATIONS					9,956	500
	CODE LETTER - D						
1	TO RECLASS INSURANCE	E	CAP REL COSTS-BLDG & FIXT	1		23,946	1
2			CAP REL COSTS-MVBLE EQUIP	2		22,103	2
500	TOTAL RECLASSIFICATIONS					46,049	500
	CODE LETTER - E						
1	TO RECLASS DEPRECIATION	F	ASSISTED LIVING	192.02		140,172	1
500	TOTAL RECLASSIFICATIONS					140,172	500
	CODE LETTER - F						
1	TO RECLASS ONCALL EXPENSE	G	OPERATING ROOM	50		147,911	1
500	TOTAL RECLASSIFICATIONS					147,911	500
	CODE LETTER - G						
1	TO RECLASS IV THERAPY TO MED SUP	H	MEDICAL SUPPLIES CHRGED TO PA	71		3,960	1
2							2
3							3
4							4
5							5
500	TOTAL RECLASSIFICATIONS					3,960	500
	CODE LETTER - H						
	GRAND TOTAL (INCREASES)					687,576	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS DRUG COST FROM PHARMACY	A	PHARMACY	15		285,501		1
500	TOTAL RECLASSIFICATIONS					285,501		500
	CODE LETTER - A							
1	TO RECLASS MED SUPPLY FROM PHARMACY	B	PHARMACY	15		1,938		1
500	TOTAL RECLASSIFICATIONS					1,938		500
	CODE LETTER - B							
1	TO RECLASS MED SUPPLY FROM OR	C	OPERATING ROOM	50		52,089		1
500	TOTAL RECLASSIFICATIONS					52,089		500
	CODE LETTER - C							
1	TO RECLASS OXGEN FROM RT TO MED SUP	D	RESPIRATORY THERAPY	65		9,956		1
500	TOTAL RECLASSIFICATIONS					9,956		500
	CODE LETTER - D							
1	TO RECLASS INSURANCE	E	GENERAL	5.02		46,049	12	1
2							12	2
500	TOTAL RECLASSIFICATIONS					46,049		500
	CODE LETTER - E							
1	TO RECLASS DEPRECIATION	F	CAP REL COSTS-BLDG & FIXT	1		140,172	9	1
500	TOTAL RECLASSIFICATIONS					140,172		500
	CODE LETTER - F							
1	TO RECLASS ONCALL EXPENSE	G	ANESTHESIOLOGY	53		147,911		1
500	TOTAL RECLASSIFICATIONS					147,911		500
	CODE LETTER - G							
1	TO RECLASS IV THERAPY TO MED SUP	H	PHARMACY	15		2,144		1
2			ADULTS & PEDIATRICS	30		331		2
3			OPERATING ROOM	50		1,210		3
4			ANESTHESIOLOGY	53		74		4
5			EMERGENCY	91		201		5
500	TOTAL RECLASSIFICATIONS					3,960		500
	CODE LETTER - H							
	GRAND TOTAL (DECREASES)					687,576		

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	237,677					237,677		1
2	LAND IMPROVEMENTS	1,580,567	46,066		46,066		1,626,633		2
3	BUILDINGS AND FIXTURES	16,304,558	2,894,134		2,894,134	2,896,221	16,302,471		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	164,333					164,333		5
6	MOVABLE EQUIPMENT	7,595,703	3,266,916		3,266,916	65,580	10,797,039		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	25,882,838	6,207,116		6,207,116	2,961,801	29,128,153		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	25,882,838	6,207,116		6,207,116	2,961,801	29,128,153		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	775,945						775,945	1
2	CAP REL COSTS-MVBLE EQUIP	881,768						881,768	2
3	TOTAL (SUM OF LINES 1-2)	1,657,713						1,657,713	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	18,093,437		18,093,437	0.626277					1
2	CAP REL COSTS-MVBLE EQUIP	10,797,039		10,797,039	0.373723					2
3	TOTAL (SUM OF LINES 1-2)	28,890,476		28,890,476	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	409,350			23,946			433,296	1
2	CAP REL COSTS-MVBLE EQUIP	627,827			22,103			649,930	2
3	TOTAL	1,037,177			46,049			1,083,226	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)	B	-67,189	CAP REL COSTS-BLDG & FIXT	1	9	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-4,732	ADMINISTRATION & ACCOUNTING	5.01		4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-11,427	ADMINISTRATION & ACCOUNTING	5.01		5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-558	GENERAL	5.02		7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-971,220				10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-289	RADIOLOGY-DIAGNOSTIC	54		11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-42,947	DIETARY	10		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1,085	MEDICAL SUPPLIES CHRGED TO PATI	71		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS						17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,292	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES	B	-17	ADMINISTRATION & ACCOUNTING	5.01		20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND	A	-250,165	CAP REL COSTS-MVBLE EQUIP	2	9	32
33	NUTRITIONAL SERVICES	A	-5,430	DIETARY	10		33
34	CRNA	A	-59,152	ANESTHESIOLOGY	53		34
35	LOBBYING PORTION OF DUES	A	-10,236	ADMINISTRATION & ACCOUNTING	5.01		35
36	MARKETING COSTS	A	-70,822	GENERAL	5.02		36
37	INTEREST EXPENSE OFFSET	A	-149,728	CAP REL COSTS-BLDG & FIXT	1	9	37
38	CASH OVER/SHORT	A	-3	GENERAL	5.02		38
39							39
40	OTHER OPERATING REVENUE	B	-55	ADMINISTRATION & ACCOUNTING	5.01		40
41	EMPLOYEE MEALS - ALF	B	-1,864	ASSISTED LIVING	192.02		41
42							42
43	ALCOHOLIC BEVERAGES	A	-696	EMPLOYEE BENEFITS	4		43
44	DIAMOND CLUB FEES	B	-8,850	GENERAL	5.02		44
45	DAYCARE REVENUE	B	-2,568	ADMINISTRATION & ACCOUNTING	5.01		45
45.01	AMBULANCE RECEIPTS	B	-3,004	ADMINISTRATION & ACCOUNTING	5.01		45.01
45.05	MEDICAID TAX ASSESSMENT	A	-123,168	GENERAL	5.02		45.05
45.06	RETIREMENT OBLIGATION	A	-1,692	CAP REL COSTS-BLDG & FIXT	1	9	45.06
45.07	ACCRETION EXPENSE	A	-7,814	CAP REL COSTS-BLDG & FIXT	1	9	45.07
45.08	PROVISION FOR BAD DEBTS	A	-1,968,846	ADMINISTRATION & ACCOUNTING	5.01		45.08
45.48	DONATIONS	A	-5,026	ADMINISTRATION & ACCOUNTING	5.01		45.48
45.49	PHYSICIAN RECRUITMENT	A	-31,131	ADMINISTRATION & ACCOUNTING	5.01		45.49
45.50	LAND RENTAL TO HILLSBORO HEALTH SV	A	-41	ADMINISTRATION & ACCOUNTING	5.01		45.50
45.51	DONATIONS	A	-650	EMPLOYEE BENEFITS	4		45.51
46							46
47	PATIENT TV DEPRECIATION	A	-3,776	CAP REL COSTS-MVBLE EQUIP	2	9	47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-3,808,473				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	LINE NO.
1	2	3	4	5	6	7	
1	66 PHYSICAL THERAPY	RENT	33,218	33,218			1
2	4 EMPLOYEE BENEFITS	WELLNESS BENEFIT	125,095	125,095			2
3							3
4							4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		158,313	158,313			5

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERA-TION INCL FRINGES 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD-JUSTED RCE LIMIT 8	5 PERCENT OF UNAD-JUSTED RCE LIMIT 9	
1	60	LABORATORY	LAB	105,155	61,200	43,955					1
2	69	ELECTROCARDIOLOGY	EKG	24,615	24,615						2
3	91	EMERGENCY	ER	1,349,734	877,455	472,279					3
4	65.50	SLEEP LAB	SLEEP LAB	7,950	7,950						4
200		TOTAL		1,487,454	971,220	516,234					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	60	LABORATORY	LAB							61,200	1
2	69	ELECTROCARDIOLOGY	EKG							24,615	2
3	91	EMERGENCY	ER							877,455	3
4	65.50	SLEEP LAB	SLEEP LAB							7,950	4
200		TOTAL								971,220	200

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	433,296	433,296				1
2	CAP REL COSTS-MVBLE EQUIP	649,930		649,930			2
4	EMPLOYEE BENEFITS	2,130,411	1,566	479	2,132,456		4
5.01	ADMINISTRATION & ACCOUNTING	979,831	63,724	18,528	49,408	1,111,491	5.01
5.02	GENERAL	491,139	63,725	225,761	62,885	843,510	5.02
5.03	ADMITTING	132,611	4,532	664	39,484	177,291	5.03
5.04	PATIENT ACCOUNTING	356,185	6,803	438	65,609	429,035	5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	591,882	28,519	7,402	70,926	698,729	7
8	LAUNDRY & LINEN SERVICE	90,527	12,570	2,473	16,008	121,578	8
9	HOUSEKEEPING	147,205	1,731	1,383	43,211	193,530	9
10	DIETARY	216,806	18,640	3,814	47,282	286,542	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	129,720	631	63	43,050	173,464	13.01
13.02	NURSING ADMINISTRATION	200,325	12,238	123	65,333	278,019	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	35,481	5,340	713	11,387	52,921	14.02
15	PHARMACY	406,374	3,375	9,215		418,964	15
16	MEDICAL RECORDS & LIBRARY	238,514	11,581	4,869	70,588	325,552	16
17	SOCIAL SERVICE	642				642	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,196,591	62,917	23,924	347,098	1,630,530	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	925,633	38,023	63,769	166,766	1,194,191	50
53	ANESTHESIOLOGY	15,262	354	5,709		21,325	53
54	RADIOLOGY-DIAGNOSTIC	902,907	21,649	118,497	131,510	1,174,563	54
54.01	ULTRA SOUND	164,796	1,304	514		166,614	54.01
56	RADIOISOTOPE	459,550	1,221	14,193	3,105	478,069	56
60	LABORATORY	962,376	11,671	46,314	145,573	1,165,934	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	138,948	5,399	4,062	38,927	187,336	65
65.50	SLEEP LAB	89,505	1,776	280	15,249	106,810	65.50
66	PHYSICAL THERAPY	773,957	20,764	16,160	238,500	1,049,381	66
67	OCCUPATIONAL THERAPY	104,586		236	34,786	139,608	67
69	ELECTROCARDIOLOGY	24,666		5,314		29,980	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	94,779				94,779	71
73	DRUGS CHARGED TO PATIENTS	285,501				285,501	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,313,234	33,243	62,196	224,895	1,633,568	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	14,683,170	433,296	637,093	1,931,580	14,469,457	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING	1,108,680		12,591	199,873	1,321,144	192.02
192.03	CARDIAC REHAB	3,011		246	1,003	4,260	192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	15,794,861	433,296	649,930	2,132,456	15,794,861	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	ADMINISTRATION & ACCOUNTING 5.01	SUBTOTAL (COLS.0-4)	GENERAL 5.02	ADMITTING 5.03	PATIENT ACCOUNTING 5.04	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING	1,111,491					5.01
5.02	GENERAL	63,851	907,361	907,361			5.02
5.03	ADMITTING	13,420	190,711	12,850	203,561		5.03
5.04	PATIENT ACCOUNTING	32,477	461,512	31,097		492,609	5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	52,892	751,621	50,644			7
8	LAUNDRY & LINEN SERVICE	9,203	130,781	8,812			8
9	HOUSEKEEPING	14,650	208,180	14,027			9
10	DIETARY	21,690	308,232	20,769			10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	13,131	186,595	12,573			13.01
13.02	NURSING ADMINISTRATION	21,045	299,064	20,151			13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	4,006	56,927	3,836			14.02
15	PHARMACY	31,714	450,678	30,367			15
16	MEDICAL RECORDS & LIBRARY	24,643	350,195	23,596			16
17	SOCIAL SERVICE	49	691	47			17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	123,426	1,753,956	118,182	16,352	39,570	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	90,397	1,284,588	86,556	21,821	52,806	50
53	ANESTHESIOLOGY	1,614	22,939	1,546	2,967	7,180	53
54	RADIOLOGY-DIAGNOSTIC	88,911	1,263,474	85,133	44,268	107,125	54
54.01	ULTRA SOUND	12,612	179,226	12,076	7,136	17,270	54.01
56	RADIOISOTOPE	36,188	514,257	34,651	11,291	27,325	56
60	LABORATORY	88,258	1,254,192	84,507	31,289	75,718	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	14,181	201,517	13,578	2,151	5,206	65
65.50	SLEEP LAB	8,085	114,895	7,742	2,131	5,157	65.50
66	PHYSICAL THERAPY	79,435	1,128,816	76,060	18,073	43,737	66
67	OCCUPATIONAL THERAPY	10,568	150,176	10,119	1,686	4,080	67
69	ELECTROCARDIOLOGY	2,269	32,249	2,173	2,433	5,887	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	7,174	101,953	6,870	6,801	16,457	71
73	DRUGS CHARGED TO PATIENTS	21,612	307,113	20,693	8,984	21,741	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	123,661	1,757,229	118,397	26,178	63,350	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,011,162	14,369,128	907,052	203,561	492,609	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING	100,007	1,421,151				192.02
192.03	CARDIAC REHAB	322	4,582	309			192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,111,491	15,794,861	907,361	203,561	492,609	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	8	9	10	11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	802,265					7
8	LAUNDRY & LINEN SERVICE	38,137	177,730				8
9	HOUSEKEEPING	5,251	10,747	238,205			9
10	DIETARY	56,552	3,826		389,379		10
11	CAFETERIA			8,454	247,656	256,110	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	1,916		4,024		5,794	13.01
13.02	NURSING ADMINISTRATION	37,129		4,024		7,199	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	16,201		6,051		4,962	14.02
15	PHARMACY	10,240		4,024			15
16	MEDICAL RECORDS & LIBRARY	35,135		4,024		17,497	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	190,890	106,260	79,470	124,391	67,864	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	115,360	10,658	47,508	17,332	23,319	50
53	ANESTHESIOLOGY	1,074		4,314			53
54	RADIOLOGY-DIAGNOSTIC	65,682	8,655	5,761		21,168	54
54.01	ULTRA SOUND	3,956		4,516			54.01
56	RADIOISOTOPE	3,706		3,966		488	56
60	LABORATORY	35,410		5,066		25,585	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	16,380		4,574		6,167	65
65.50	SLEEP LAB	5,389	1,137	4,111		2,467	65.50
66	PHYSICAL THERAPY	62,997	19,966	7,759		32,383	66
67	OCCUPATIONAL THERAPY			5,674		4,704	67
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	100,860	16,481	34,885		36,513	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	802,265	177,730	238,205	389,379	256,110	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	802,265	177,730	238,205	389,379	256,110	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	UR/QUALITY IMPROVEMENT 13.01	NURSING ADMINISTRATION 13.02	CENTRAL SERVICES & SUPPLY 14.02	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
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
13.01	UR/QUALITY IMPROVEMENT	210,902					13.01
13.02	NURSING ADMINISTRATION		367,567				13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY			87,977			14.02
15	PHARMACY			800	496,109		15
16	MEDICAL RECORDS & LIBRARY			386		430,833	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	210,902	179,727	8,416	5,179	120,858	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		74,793	27,494	652	49,559	50
53	ANESTHESIOLOGY			881	2,675		53
54	RADIOLOGY-DIAGNOSTIC			3,501	21,798	127,403	54
54.01	ULTRA SOUND			195			54.01
56	RADIOISOTOPE			981	35,348		56
60	LABORATORY		15	34,388		24,779	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,854	1,626	25	3,740	65
65.50	SLEEP LAB		1,854	11		4,675	65.50
66	PHYSICAL THERAPY			1,234	3	8,883	66
67	OCCUPATIONAL THERAPY			76		234	67
69	ELECTROCARDIOLOGY			140			69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS			2,736			71
73	DRUGS CHARGED TO PATIENTS				427,926		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		109,324	5,112	2,503	90,702	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	210,902	367,567	87,977	496,109	430,833	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	210,902	367,567	87,977	496,109	430,833	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		17	24	25	26	
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS					4
5.01	ADMINISTRATION & ACCOUNTING					5.01
5.02	GENERAL					5.02
5.03	ADMITTING					5.03
5.04	PATIENT ACCOUNTING					5.04
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
13.01	UR/QUALITY IMPROVEMENT					13.01
13.02	NURSING ADMINISTRATION					13.02
14	CENTRAL SERVICES & SUPPLY					14
14.01	PURCHASING					14.01
14.02	CENTRAL SERVICES & SUPPLY					14.02
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE	738				17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SRVCES-SALARY & FRINGES APPRVD					21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	738	3,022,755		3,022,755	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM		1,812,446		1,812,446	50
53	ANESTHESIOLOGY		43,576		43,576	53
54	RADIOLOGY-DIAGNOSTIC		1,753,968		1,753,968	54
54.01	ULTRA SOUND		224,375		224,375	54.01
56	RADIOISOTOPE		632,013		632,013	56
60	LABORATORY		1,570,949		1,570,949	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		256,818		256,818	65
65.50	SLEEP LAB		149,569		149,569	65.50
66	PHYSICAL THERAPY		1,399,911		1,399,911	66
67	OCCUPATIONAL THERAPY		176,749		176,749	67
69	ELECTROCARDIOLOGY		42,882		42,882	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		134,817		134,817	71
73	DRUGS CHARGED TO PATIENTS		786,457		786,457	73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	EMERGENCY		2,361,534		2,361,534	91
92	OBSERVATION BEDS					92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	738	14,368,819		14,368,819	118
	NONREIMBURSABLE COST CENTERS					
192.02	ASSISTED LIVING		1,421,151		1,421,151	192.02
192.03	CARDIAC REHAB		4,891		4,891	192.03
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	738	15,794,861		15,794,861	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 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS		1,566	479	2,045	2,045	4
5.01	ADMINISTRATION & ACCOUNTING		63,724	18,528	82,252	47	5.01
5.02	GENERAL		63,725	225,761	289,486	60	5.02
5.03	ADMITTING		4,532	664	5,196	38	5.03
5.04	PATIENT ACCOUNTING		6,803	438	7,241	63	5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		28,519	7,402	35,921	68	7
8	LAUNDRY & LINEN SERVICE		12,570	2,473	15,043	15	8
9	HOUSEKEEPING		1,731	1,383	3,114	41	9
10	DIETARY		18,640	3,814	22,454	45	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT		631	63	694	41	13.01
13.02	NURSING ADMINISTRATION		12,238	123	12,361	63	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		5,340	713	6,053	11	14.02
15	PHARMACY		3,375	9,215	12,590		15
16	MEDICAL RECORDS & LIBRARY		11,581	4,869	16,450	68	16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		62,917	23,924	86,841	333	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		38,023	63,769	101,792	160	50
53	ANESTHESIOLOGY		354	5,709	6,063		53
54	RADIOLOGY-DIAGNOSTIC		21,649	118,497	140,146	126	54
54.01	ULTRA SOUND		1,304	514	1,818		54.01
56	RADIOISOTOPE		1,221	14,193	15,414	3	56
60	LABORATORY		11,671	46,314	57,985	140	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		5,399	4,062	9,461	37	65
65.50	SLEEP LAB		1,776	280	2,056	15	65.50
66	PHYSICAL THERAPY		20,764	16,160	36,924	229	66
67	OCCUPATIONAL THERAPY			236	236	33	67
69	ELECTROCARDIOLOGY			5,314	5,314		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		33,243	62,196	95,439	216	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		433,296	637,093	1,070,389	1,852	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING			12,591	12,591	192	192.02
192.03	CARDIAC REHAB			246	246	1	192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		433,296	649,930	1,083,226	2,045	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	ADMINISTRATION & ACCOUNTING 5.01	GENERAL 5.02	ADMITTING 5.03	PATIENT ACCOUNTING 5.04	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING	82,299					5.01
5.02	GENERAL	4,728	294,274				5.02
5.03	ADMITTING	994	4,168	10,396			5.03
5.04	PATIENT ACCOUNTING	2,405	10,085		19,794		5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	3,916	16,425			56,330	7
8	LAUNDRY & LINEN SERVICE	681	2,858			2,678	8
9	HOUSEKEEPING	1,085	4,549			369	9
10	DIETARY	1,606	6,736			3,971	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	972	4,078			134	13.01
13.02	NURSING ADMINISTRATION	1,558	6,535			2,607	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	297	1,244			1,138	14.02
15	PHARMACY	2,348	9,849			719	15
16	MEDICAL RECORDS & LIBRARY	1,825	7,653			2,467	16
17	SOCIAL SERVICE	4	15				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	9,139	38,329	835	1,590	13,403	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	6,693	28,072	1,115	2,122	8,100	50
53	ANESTHESIOLOGY	120	501	152	289	75	53
54	RADIOLOGY-DIAGNOSTIC	6,583	27,611	2,259	4,302	4,612	54
54.01	ULTRA SOUND	934	3,917	365	694	278	54.01
56	RADIOISOTOPE	2,680	11,238	577	1,098	260	56
60	LABORATORY	6,535	27,408	1,598	3,043	2,486	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,050	4,404	110	209	1,150	65
65.50	SLEEP LAB	599	2,511	109	207	378	65.50
66	PHYSICAL THERAPY	5,882	24,668	923	1,758	4,423	66
67	OCCUPATIONAL THERAPY	783	3,282	86	164		67
69	ELECTROCARDIOLOGY	168	705	124	237		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	531	2,228	347	661		71
73	DRUGS CHARGED TO PATIENTS	1,600	6,711	459	874		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	9,154	38,394	1,337	2,546	7,082	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	74,870	294,174	10,396	19,794	56,330	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING	7,405					192.02
192.03	CARDIAC REHAB	24	100				192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	82,299	294,274	10,396	19,794	56,330	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	UR/QUALITY IMPROVEMENT	
		8	9	10	11	13.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	21,275					8
9	HOUSEKEEPING	1,287	10,445				9
10	DIETARY	458		35,270			10
11	CAFETERIA		371	22,433	22,804		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT		176		516	6,611	13.01
13.02	NURSING ADMINISTRATION		176		641		13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		265		442		14.02
15	PHARMACY		176				15
16	MEDICAL RECORDS & LIBRARY		176		1,558		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	12,719	3,486	11,267	6,043	6,611	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,276	2,083	1,570	2,076		50
53	ANESTHESIOLOGY		189				53
54	RADIOLOGY-DIAGNOSTIC	1,036	253		1,885		54
54.01	ULTRA SOUND		198				54.01
56	RADIOISOTOPE		174		43		56
60	LABORATORY		222		2,278		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		201		549		65
65.50	SLEEP LAB	136	180		220		65.50
66	PHYSICAL THERAPY	2,390	340		2,883		66
67	OCCUPATIONAL THERAPY		249		419		67
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,973	1,530		3,251		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	21,275	10,445	35,270	22,804	6,611	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	21,275	10,445	35,270	22,804	6,611	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	NURSING ADMINISTRATION 13.02	CENTRAL SERVICES & SUPPLY 14.02	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
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
13.01	UR/QUALITY IMPROVEMENT						13.01
13.02	NURSING ADMINISTRATION	23,941					13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		9,450				14.02
15	PHARMACY		86	25,768			15
16	MEDICAL RECORDS & LIBRARY		41		30,238		16
17	SOCIAL SERVICE					19	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	11,705	904	269	8,482	19	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,872	2,953	34	3,478		50
53	ANESTHESIOLOGY		95	139			53
54	RADIOLOGY-DIAGNOSTIC		376	1,132	8,943		54
54.01	ULTRA SOUND		21				54.01
56	RADIOISOTOPE		105	1,836			56
60	LABORATORY	1	3,694		1,739		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	121	175	1	263		65
65.50	SLEEP LAB	121	1		328		65.50
66	PHYSICAL THERAPY		133		623		66
67	OCCUPATIONAL THERAPY		8		16		67
69	ELECTROCARDIOLOGY		15				69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		294				71
73	DRUGS CHARGED TO PATIENTS			22,227			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	7,121	549	130	6,366		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	23,941	9,450	25,768	30,238	19	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	23,941	9,450	25,768	30,238	19	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1
2	CAP REL COSTS-MVBLE EQUIP				2
4	EMPLOYEE BENEFITS				4
5.01	ADMINISTRATION & ACCOUNTING				5.01
5.02	GENERAL				5.02
5.03	ADMITTING				5.03
5.04	PATIENT ACCOUNTING				5.04
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
13.01	UR/QUALITY IMPROVEMENT				13.01
13.02	NURSING ADMINISTRATION				13.02
14	CENTRAL SERVICES & SUPPLY				14
14.01	PURCHASING				14.01
14.02	CENTRAL SERVICES & SUPPLY				14.02
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY				16
17	SOCIAL SERVICE				17
19	NONPHYSICIAN ANESTHETISTS				19
20	NURSING SCHOOL				20
21	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	PARAMED ED PRGM-(SPECIFY)				23
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS	211,975		211,975	30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	166,396		166,396	50
53	ANESTHESIOLOGY	7,623		7,623	53
54	RADIOLOGY-DIAGNOSTIC	199,264		199,264	54
54.01	ULTRA SOUND	8,225		8,225	54.01
56	RADIOISOTOPE	33,428		33,428	56
60	LABORATORY	107,129		107,129	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	17,731		17,731	65
65.50	SLEEP LAB	6,861		6,861	65.50
66	PHYSICAL THERAPY	81,176		81,176	66
67	OCCUPATIONAL THERAPY	5,276		5,276	67
69	ELECTROCARDIOLOGY	6,563		6,563	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	4,061		4,061	71
73	DRUGS CHARGED TO PATIENTS	31,871		31,871	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	175,088		175,088	91
92	OBSERVATION BEDS				92
	OTHER REIMBURSABLE COST CENTERS				
99.10	CORF				99.10
99.20	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	OUTPATIENT SPEECH PATHOLOGY				99.40
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (SUM OF LINES 1-117)	1,062,667	1,062,667		118
	NONREIMBURSABLE COST CENTERS				
192.02	ASSISTED LIVING	20,188	20,188		192.02
192.03	CARDIAC REHAB	371	371		192.03
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	TOTAL (SUM OF LINES 118-201)	1,083,226	1,083,226		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 GROSS SALARIES 4	RECONCILIATION 5A.01	ADMINISTRATION & ACCOUNTING ACCUM COST 5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	7,343,399					1
2	CAP REL COSTS-MVBLE EQUIP		881,766				2
4	EMPLOYEE BENEFITS	26,545	650	6,213,289			4
5.01	ADMINISTRATION & ACCOUNTING	1,079,995	25,137	143,960	-1,111,491	14,683,370	5.01
5.02	GENERAL	1,079,995	306,292	183,226		843,510	5.02
5.03	ADMITTING	76,800	901	115,043		177,291	5.03
5.04	PATIENT ACCOUNTING	115,300	594	191,164		429,035	5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	483,333	10,043	206,654		698,729	7
8	LAUNDRY & LINEN SERVICE	213,033	3,355	46,643		121,578	8
9	HOUSEKEEPING	29,333	1,877	125,903		193,530	9
10	DIETARY	315,900	5,174	137,763		286,542	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT	10,700	85	125,433		173,464	13.01
13.02	NURSING ADMINISTRATION	207,400	167	190,358		278,019	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY	90,500	967	33,179		52,921	14.02
15	PHARMACY	57,200	12,502			418,964	15
16	MEDICAL RECORDS & LIBRARY	196,265	6,606	205,672		325,552	16
17	SOCIAL SERVICE					642	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,066,300	32,458	1,011,333		1,630,530	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	644,400	86,516	485,901		1,194,191	50
53	ANESTHESIOLOGY	6,000	7,746			21,325	53
54	RADIOLOGY-DIAGNOSTIC	366,900	160,766	383,179		1,174,563	54
54.01	ULTRA SOUND	22,100	697			166,614	54.01
56	RADIOISOTOPE	20,700	19,256	9,047		478,069	56
60	LABORATORY	197,800	62,834	424,152		1,165,934	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	91,500	5,511	113,421		187,336	65
65.50	SLEEP LAB	30,100	380	44,432		106,810	65.50
66	PHYSICAL THERAPY	351,900	21,925	694,913		1,049,381	66
67	OCCUPATIONAL THERAPY		320	101,356		139,608	67
69	ELECTROCARDIOLOGY		7,209			29,980	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS					94,779	71
73	DRUGS CHARGED TO PATIENTS					285,501	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	563,400	84,382	655,270		1,633,568	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	7,343,399	864,350	5,628,002	-1,111,491	13,357,966	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING		17,082	582,364		1,321,144	192.02
192.03	CARDIAC REHAB		334	2,923		4,260	192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	433,296	649,930	2,132,456		1,111,491	202
203	UNIT COST MULT-WS B PT I	0.059005	0.737078	0.343209		0.075697	203
204	COST TO BE ALLOC PER B PT II			2,045		82,299	204
205	UNIT COST MULT-WS B PT II			0.000329		0.005605	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	RECON-CILIATION	GENERAL ACCUM COST 5.02	ADMITTING GROSS CHARGES 5.03	PATIENT ACCOUNTING GROSS CHARGES 5.04	OPERATION OF PLANT SQUARE FEET 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL	-907,361	13,466,349				5.02
5.03	ADMITTING		190,711	30,228,700			5.03
5.04	PATIENT ACCOUNTING		461,512		30,228,700		5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		751,621			4,481,431	7
8	LAUNDRY & LINEN SERVICE		130,781			213,033	8
9	HOUSEKEEPING		208,180			29,333	9
10	DIETARY		308,232			315,900	10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT		186,595			10,700	13.01
13.02	NURSING ADMINISTRATION		299,064			207,400	13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		56,927			90,500	14.02
15	PHARMACY		450,678			57,200	15
16	MEDICAL RECORDS & LIBRARY		350,195			196,265	16
17	SOCIAL SERVICE		691				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		1,753,956	2,428,206	2,428,206	1,066,300	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,284,588	3,240,454	3,240,454	644,400	50
53	ANESTHESIOLOGY		22,939	440,606	440,606	6,000	53
54	RADIOLOGY-DIAGNOSTIC		1,263,474	6,573,514	6,573,514	366,900	54
54.01	ULTRA SOUND		179,226	1,059,753	1,059,753	22,100	54.01
56	RADIOISOTOPE		514,257	1,676,769	1,676,769	20,700	56
60	LABORATORY		1,254,192	4,646,392	4,646,392	197,800	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		201,517	319,441	319,441	91,500	65
65.50	SLEEP LAB		114,895	316,484	316,484	30,100	65.50
66	PHYSICAL THERAPY		1,128,816	2,683,904	2,683,904	351,900	66
67	OCCUPATIONAL THERAPY		150,176	250,392	250,392		67
69	ELECTROCARDIOLOGY		32,249	361,274	361,274		69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		101,953	1,009,910	1,009,910		71
73	DRUGS CHARGED TO PATIENTS		307,113	1,334,122	1,334,122		73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		1,757,229	3,887,479	3,887,479	563,400	91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	-907,361	13,461,767	30,228,700	30,228,700	4,481,431	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING	-1,421,151					192.02
192.03	CARDIAC REHAB		4,582				192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I		907,361	203,561	492,609	802,265	202
203	UNIT COST MULT-WS B PT I		0.067380	0.006734	0.016296	0.179020	203
204	COST TO BE ALLOC PER B PT II		294,274	10,396	19,794	56,330	204
205	UNIT COST MULT-WS B PT II		0.021853	0.000344	0.000655	0.012570	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 8	HOUSE-KEEPING HOURS OF SERVICE 9	DIETARY MEALS SERVED 10	CAFETERIA FTE'S SERVED 11	UR/QUALITY IMPROVEMENT DIRECT NRS ING HRS 13.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	159,881					8
9	HOUSEKEEPING	9,668	8,228				9
10	DIETARY	3,442		32,868			10
11	CAFETERIA		292	20,905	8,929		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
13.01	UR/QUALITY IMPROVEMENT		139		202	3,007	13.01
13.02	NURSING ADMINISTRATION		139		251		13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		209		173		14.02
15	PHARMACY		139				15
16	MEDICAL RECORDS & LIBRARY		139		610		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	95,587	2,745	10,500	2,366	3,007	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,588	1,641	1,463	813		50
53	ANESTHESIOLOGY		149				53
54	RADIOLOGY-DIAGNOSTIC	7,786	199		738		54
54.01	ULTRA SOUND		156				54.01
56	RADIOISOTOPE		137		17		56
60	LABORATORY		175		892		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		158		215		65
65.50	SLEEP LAB	1,023	142		86		65.50
66	PHYSICAL THERAPY	17,961	268		1,129		66
67	OCCUPATIONAL THERAPY		196		164		67
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	14,826	1,205		1,273		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	159,881	8,228	32,868	8,929	3,007	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	177,730	238,205	389,379	256,110	210,902	202
203	UNIT COST MULT-WS B PT I	1.111639	28.950535	11.846751	28.682943	70.137014	203
204	COST TO BE ALLOC PER B PT II	21,275	10,445	35,270	22,804	6,611	204
205	UNIT COST MULT-WS B PT II	0.133068	1.269446	1.073080	2.553925	2.198537	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINISTRATION DIRECT NRSING HRS 13.02	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14.02	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
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
13.01	UR/QUALITY IMPROVEMENT						13.01
13.02	NURSING ADMINISTRATION	49,572					13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY		810,915				14.02
15	PHARMACY		7,371	330,991			15
16	MEDICAL RECORDS & LIBRARY		3,558		1,843		16
17	SOCIAL SERVICE					100	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	24,239	77,570	3,455	517	100	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	10,087	253,422	435	212		50
53	ANESTHESIOLOGY		8,123	1,785			53
54	RADIOLOGY-DIAGNOSTIC		32,272	14,543	545		54
54.01	ULTRA SOUND		1,797				54.01
56	RADIOISOTOPE		9,040	23,583			56
60	LABORATORY	2	316,967		106		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	250	14,986	17	16		65
65.50	SLEEP LAB	250	103		20		65.50
66	PHYSICAL THERAPY		11,378	2	38		66
67	OCCUPATIONAL THERAPY		703		1		67
69	ELECTROCARDIOLOGY		1,292				69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS		25,215				71
73	DRUGS CHARGED TO PATIENTS			285,501			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	14,744	47,118	1,670	388		91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	49,572	810,915	330,991	1,843	100	118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	367,567	87,977	496,109	430,833	738	202
203	UNIT COST MULT-WS B PT I	7.414811	0.108491	1.498859	233.767227	7.380000	203
204	COST TO BE ALLOC PER B PT II	23,941	9,450	25,768	30,238	19	204
205	UNIT COST MULT-WS B PT II	0.482954	0.011654	0.077851	16.406945	0.190000	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5.01	ADMINISTRATION & ACCOUNTING	5.01
5.02	GENERAL	5.02
5.03	ADMITTING	5.03
5.04	PATIENT ACCOUNTING	5.04
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
13.01	UR/QUALITY IMPROVEMENT	13.01
13.02	NURSING ADMINISTRATION	13.02
14	CENTRAL SERVICES & SUPPLY	14
14.01	PURCHASING	14.01
14.02	CENTRAL SERVICES & SUPPLY	14.02
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
54.01	ULTRA SOUND	54.01
56	RADIOISOTOPE	56
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
65.50	SLEEP LAB	65.50
66	PHYSICAL THERAPY	66
67	OCCUPATIONAL THERAPY	67
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGED TO PATIENTS	71
73	DRUGS CHARGED TO PATIENTS	73
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
192.02	ASSISTED LIVING	192.02
192.03	CARDIAC REHAB	192.03
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	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	3,022,755		3,022,755			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,812,446		1,812,446			50
53	ANESTHESIOLOGY	43,576		43,576			53
54	RADIOLOGY-DIAGNOSTIC	1,753,968		1,753,968			54
54.01	ULTRA SOUND	224,375		224,375			54.01
56	RADIOISOTOPE	632,013		632,013			56
60	LABORATORY	1,570,949		1,570,949			60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	256,818		256,818			65
65.50	SLEEP LAB	149,569		149,569			65.50
66	PHYSICAL THERAPY	1,399,911		1,399,911			66
67	OCCUPATIONAL THERAPY	176,749		176,749			67
69	ELECTROCARDIOLOGY	42,882		42,882			69
71	MEDICAL SUPPLIES CHRGED TO	134,817		134,817			71
73	DRUGS CHARGED TO PATIENTS	786,457		786,457			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,361,534		2,361,534			91
92	OBSERVATION BEDS	353,640		353,640			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THE						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	14,722,459		14,722,459			200
201	LESS OBSERVATION BEDS	353,640		353,640			201
202	TOTAL (SEE INSTRUCTIONS)	14,368,819		14,368,819			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	2,428,206		2,428,206				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	107,779	3,132,675	3,240,454	0.559319			50
53	ANESTHESIOLOGY	16,244	424,362	440,606	0.098900			53
54	RADIOLOGY-DIAGNOSTIC	323,325	6,250,189	6,573,514	0.266823			54
54.01	ULTRA SOUND	116,108	943,645	1,059,753	0.211724			54.01
56	RADIOISOTOPE	30,862	1,645,907	1,676,769	0.376923			56
60	LABORATORY	597,319	4,049,063	4,646,382	0.338102			60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	189,248	130,193	319,441	0.803961			65
65.50	SLEEP LAB	6,217	310,267	316,484	0.472596			65.50
66	PHYSICAL THERAPY	297,669	2,386,235	2,683,904	0.521595			66
67	OCCUPATIONAL THERAPY	143,685	106,707	250,392	0.705889			67
69	ELECTROCARDIOLOGY	24,538	336,736	361,274	0.118697			69
71	MEDICAL SUPPLIES CHRGED TO	327,010	682,900	1,009,910	0.133494			71
73	DRUGS CHARGED TO PATIENTS	515,311	818,811	1,334,122	0.589494			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY		3,887,479	3,887,479	0.607472			91
92	OBSERVATION BEDS	145,566	618,106	763,672	0.463078			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THE							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	5,269,087	25,723,275	30,992,362				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		25,723,275	30,992,362				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1332)	[ ]	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	0.559319		1,605,269			897,857		50
53	ANESTHESIOLOGY	0.098900		206,376			20,411		53
54	RADIOLOGY-DIAGNOSTIC	0.266823		2,351,034			627,310		54
54.01	ULTRA SOUND	0.211724		435,440			92,193		54.01
56	RADIOISOTOPE	0.376923		645,340			243,243		56
60	LABORATORY	0.338102		1,832,764			619,661		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.803961		47,356			38,072		65
65.50	SLEEP LAB	0.472596		122,008			57,660		65.50
66	PHYSICAL THERAPY	0.521595		880,449			459,238		66
67	OCCUPATIONAL THERAPY	0.705889		33,902			23,931		67
69	ELECTROCARDIOLOGY	0.118697		146,017			17,332		69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494		388,484			51,860		71
73	DRUGS CHARGED TO PATIENTS	0.589494		598,037			352,539		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.607472		1,390,795			844,869		91
92	OBSERVATION BEDS	0.463078		215,621			99,849		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)			10,898,892			4,446,025		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			10,898,892			4,446,025		202

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

CHECK	[ ]	TITLE V - O/P	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B-SNF (14-Z332)	
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	0.559319							50
53	ANESTHESIOLOGY	0.098900							53
54	RADIOLOGY-DIAGNOSTIC	0.266823							54
54.01	ULTRA SOUND	0.211724							54.01
56	RADIOISOTOPE	0.376923							56
60	LABORATORY	0.338102							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.803961							65
65.50	SLEEP LAB	0.472596							65.50
66	PHYSICAL THERAPY	0.521595							66
67	OCCUPATIONAL THERAPY	0.705889							67
69	ELECTROCARDIOLOGY	0.118697							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494							71
73	DRUGS CHARGED TO PATIENTS	0.589494							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.607472							91
92	OBSERVATION BEDS	0.463078							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

CHECK 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	211,975	104,999	106,976	1,678	63.75	62	3,953	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	211,975		106,976	1,678		62	3,953	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1332)	[ ]	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	166,396	3,240,454	0.051350			50
53	ANESTHESIOLOGY	7,623	440,606	0.017301			53
54	RADIOLOGY-DIAGNOSTIC	199,264	6,573,514	0.030313			54
54.01	ULTRA SOUND	8,225	1,059,753	0.007761			54.01
56	RADIOISOTOPE	33,428	1,676,769	0.019936			56
60	LABORATORY	107,129	4,646,382	0.023056			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	17,731	319,441	0.055506			65
65.50	SLEEP LAB	6,861	316,484	0.021679			65.50
66	PHYSICAL THERAPY	81,176	2,683,904	0.030245			66
67	OCCUPATIONAL THERAPY	5,276	250,392	0.021071			67
69	ELECTROCARDIOLOGY	6,563	361,274	0.018166			69
71	MEDICAL SUPPLIES CHRGED TO PA	4,061	1,009,910	0.004021			71
73	DRUGS CHARGED TO PATIENTS	31,871	1,334,122	0.023889			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	175,088	3,887,479	0.045039			91
92	OBSERVATION BEDS	49,141	763,672	0.064348			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)	899,833	28,564,156				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	1,678		62		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)	1,678		62		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1332)	[ ]	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
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRA SOUND							54.01
56	RADIOISOTOPE							56
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
65.50	SLEEP LAB							65.50
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHRGED TO PA							71
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY							91
92	OBSERVATION BEDS							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK	[ ] TITLE V	[XX]	HOSPITAL (14-1332)	[ ]	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)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	3,240,454							50
53	ANESTHESIOLOGY	440,606							53
54	RADIOLOGY-DIAGNOSTIC	6,573,514							54
54.01	ULTRA SOUND	1,059,753							54.01
56	RADIOISOTOPE	1,676,769							56
60	LABORATORY	4,646,382							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	319,441							65
65.50	SLEEP LAB	316,484							65.50
66	PHYSICAL THERAPY	2,683,904							66
67	OCCUPATIONAL THERAPY	250,392							67
69	ELECTROCARDIOLOGY	361,274							69
71	MEDICAL SUPPLIES CHRGED TO P	1,009,910							71
73	DRUGS CHARGED TO PATIENTS	1,334,122							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	3,887,479							91
92	OBSERVATION BEDS	763,672							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (SUM OF LINES 50-199)	28,564,156							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1332)	[ ]	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	0.559319							50
53	ANESTHESIOLOGY	0.098900							53
54	RADIOLOGY-DIAGNOSTIC	0.266823							54
54.01	ULTRA SOUND	0.211724							54.01
56	RADIOISOTOPE	0.376923							56
60	LABORATORY	0.338102							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.803961							65
65.50	SLEEP LAB	0.472596							65.50
66	PHYSICAL THERAPY	0.521595							66
67	OCCUPATIONAL THERAPY	0.705889							67
69	ELECTROCARDIOLOGY	0.118697							69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494							71
73	DRUGS CHARGED TO PATIENTS	0.589494							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.607472							91
92	OBSERVATION BEDS	0.463078							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1332)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[ ]	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)	3,325	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,678	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,289	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,647	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)	1,033	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)	1,647	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	130.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	130.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,022,755	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)	1,497,288	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,525,467	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,143,900	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,143,900	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.333567	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)	887.43	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)	1,525,467	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 (14-1332) [ ] IPF [ ] IRF | [ ] SUB (OTHER) | [ ] PPS [ ] TEFRA [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)	909.10	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	939,100	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)	939,100	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					498,354	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,437,454	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)						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						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)					1,497,288	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)					1,497,288	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)	389	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	909.10	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	353,640	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	211,975	1,525,467	0.138957	353,640	49,141	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1

COMPUTATION OF INPATIENT OPERATING COST — PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1332)	[ ]	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)	3,325	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,678	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,289	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	1,647	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)	62	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	130.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	130.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,022,755	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)	1,497,288	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,525,467	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,143,900	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,143,900	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.333567	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)	887.43	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)	1,525,467	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1332)	[ ]	SUB (OTHER)	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
BOXES	[XX]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	909.10	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	56,364	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)	56,364	41

		TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					56,364	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					3,953	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					3,953	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)	389	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 (14-1332)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	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		1,009,946		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.559319	58,740	32,854	50
53	ANESTHESIOLOGY	0.098900	10,154	1,004	53
54	RADIOLOGY-DIAGNOSTIC	0.266823	198,453	52,952	54
54.01	ULTRA SOUND	0.211724	97,927	20,733	54.01
56	RADIOISOTOPE	0.376923	27,617	10,409	56
60	LABORATORY	0.338102	333,662	112,812	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.803961	94,786	76,204	65
65.50	SLEEP LAB	0.472596			65.50
66	PHYSICAL THERAPY	0.521595	41,239	21,510	66
67	OCCUPATIONAL THERAPY	0.705889	11,448	8,081	67
69	ELECTROCARDIOLOGY	0.118697	20,123	2,389	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494	184,880	24,680	71
73	DRUGS CHARGED TO PATIENTS	0.589494	228,546	134,726	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.607472			91
92	OBSERVATION BEDS	0.463078			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		1,307,575	498,354	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		1,307,575		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z332)	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.559319	221	124	50
53	ANESTHESIOLOGY	0.098900			53
54	RADIOLOGY-DIAGNOSTIC	0.266823	74,822	19,964	54
54.01	ULTRA SOUND	0.211724	18,181	3,849	54.01
56	RADIOISOTOPE	0.376923	2,622	988	56
60	LABORATORY	0.338102	181,571	61,390	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.803961	77,113	61,996	65
65.50	SLEEP LAB	0.472596	6,217	2,938	65.50
66	PHYSICAL THERAPY	0.521595	243,878	127,206	66
67	OCCUPATIONAL THERAPY	0.705889	127,723	90,158	67
69	ELECTROCARDIOLOGY	0.118697	4,415	524	69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494	89,122	11,897	71
73	DRUGS CHARGED TO PATIENTS	0.589494	223,971	132,030	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.607472			91
92	OBSERVATION BEDS	0.463078			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		1,049,856	513,064	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		1,049,856		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1332)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.559319			50
53	ANESTHESIOLOGY	0.098900			53
54	RADIOLOGY-DIAGNOSTIC	0.266823			54
54.01	ULTRA SOUND	0.211724			54.01
56	RADIOISOTOPE	0.376923			56
60	LABORATORY	0.338102			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.803961			65
65.50	SLEEP LAB	0.472596			65.50
66	PHYSICAL THERAPY	0.521595			66
67	OCCUPATIONAL THERAPY	0.705889			67
69	ELECTROCARDIOLOGY	0.118697			69
71	MEDICAL SUPPLIES CHRGED TO PATI	0.133494			71
73	DRUGS CHARGED TO PATIENTS	0.589494			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.607472			91
92	OBSERVATION BEDS	0.463078			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1332) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,446,025	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)	4,446,025	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)		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)	4,490,485	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)	40,359	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,825,175	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,624,951	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)	2,624,951	30
31	PRIMARY PAYER PAYMENTS	3,062	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,621,889	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)	298,617	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	298,617	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	298,617	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	2,920,506	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	2,920,506	40
41	INTERIM PAYMENTS	3,231,958	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-311,452	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 (14-1332) [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] SWING BED SNF

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,212,955		3,309,143	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	01/11/2013	34,367		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			3.50
			.51			01/01/2013	77,185	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		34,367		-77,185	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)				1,247,322		3,231,958	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					6.01
		PROVIDER TO PROGRAM	.02		-66,857		-311,452	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,180,465		2,920,506	7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-Z332)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2,092,034			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		17,339		NONE	3.01
	PROGRAM TO PROVIDER	.02					3.02
		.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		17,339			3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				2,109,373			4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01		NONE		NONE	5.01
		.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
	PROVIDER TO PROGRAM	.50		NONE		NONE	5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02		-137,077			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				1,972,296			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 (14-1332) [ ] 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	431	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,033	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	11	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,289	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	30,992,362	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,034,181	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	1,180,743	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,180,743	8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	1,180,743	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS WORKSHEET E-2

CHECK	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z332)
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF
BOXES	[ ]	TITLE XIX		

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	1,512,261		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)			2
3	ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	518,195		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	1,647		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	2,030,456		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	2,030,456		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	2,030,456		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	58,160		13
14	80% OF PART B COSTS (LINE 12 x 80%)			14
15	SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	1,972,296		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17
18	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	1,972,296		19
20	INTERIM PAYMENTS	2,109,373		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-137,077		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1332)
APPLICABLE BOX: [ ] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	1,437,454	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	1,437,454	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	1,451,829	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	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)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	1,451,829	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	292,980	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,158,849	22
23	COINSURANCE	9,475	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,149,374	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	31,091	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	31,091	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	31,091	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,180,465	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,180,465	30
31	INTERIM PAYMENTS	1,247,322	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-66,857	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART VII

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1332)	[ ]	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	56,364		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	56,364		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	56,364		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)			15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)			18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	56,364		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	56,364		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)	56,364		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)	56,364		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)	56,364		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)	56,364		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	56,364		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,817,306				1
2	TEMPORARY INVESTMENTS	138,022				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,161,412				4
5	OTHER RECEIVABLES	74,125				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,349,000				6
7	INVENTORY	358,993				7
8	PREPAID EXPENSES	218,853				8
9	OTHER CURRENT ASSETS	168,545				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	5,588,256				11
	FIXED ASSETS					
12	LAND	237,676				12
13	LAND IMPROVEMENTS	1,626,633				13
14	ACCUMULATED DEPRECIATION	-656,764				14
15	BUILDINGS	16,309,429				15
16	ACCUMULATED DEPRECIATION	-6,297,727				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	164,333				19
20	ACCUMULATED DEPRECIATION	-161,873				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	10,797,039				23
24	ACCUMULATED DEPRECIATION	-6,174,631				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)	15,844,115				30
	OTHER ASSETS					
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	10,841,994				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	10,841,994				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	32,274,365				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,247,184				37
38	SALARIES, WAGES & FEES PAYABLE	517,560				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	242,683				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	1,074,689				43
44	OTHER CURRENT LIABILITIES					44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	4,082,116				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	6,473,709				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	6,473,709				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,555,825				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	21,718,540				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	21,718,540				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	32,274,365				60

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD	19,636,948								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	1,836,744								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	21,473,692								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	RETURN ON INVESTMENTS	5,608								5
6	CONTRIBUTIONS OF EQUIPTMENT	37,289								6
7	TRANSFERS FROM FOUNDATION	209,967								7
8	UNREALIZED CHANGE IN INVESTMENTS	219,845								8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)	472,709								10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	21,946,401								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	RELEASED CONTRIBUTIONS	223,572								13
14	CHANGE IN INTEREST OF FOUNDATION	4,289								14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)	227,861								18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	21,718,540								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	3,329,908		3,329,908	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	3,329,908		3,329,908	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	3,329,908		3,329,908	17
18	ANCILLARY SERVICES	4,018,455		4,018,455	18
19	OUTPATIENT SERVICES		27,065,986	27,065,986	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	7,348,363	27,065,986	34,414,349	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		19,603,334	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43	TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		19,603,334	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	34,414,349	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	14,628,782	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	19,785,567	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	19,603,334	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	182,233	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	145,800	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	4,732	10
11	REBATES AND REFUNDS OF EXPENSES	11,427	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	44,811	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4,292	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	2,568	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC. INCOME/ADJUSTMENTS)	79,338	24
24.01	OTHER (EHR INCENTIVE PAYMENTS)	1,361,543	24.01
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,654,511	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,836,744	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,836,744	29

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS						4
5.01	ADMINISTRATION & ACCOUNTING						5.01
5.02	GENERAL						5.02
5.03	ADMITTING						5.03
5.04	PATIENT ACCOUNTING						5.04
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
13.01	UR/QUALITY IMPROVEMENT						13.01
13.02	NURSING ADMINISTRATION						13.02
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES AP						21
22	I&R SRVCES-OTHER PRGM COSTS AP						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	ULTRA SOUND						54.01
56	RADIOISOTOPE						56
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
65.50	SLEEP LAB						65.50
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PAT						71
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAP						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
192.02	ASSISTED LIVING						192.02
192.03	CARDIAC REHAB						192.03
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