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: 11-24-2013 TIME: 13:32_____
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 MEMORIAL HOSPITAL (14-1338) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2012 AND ENDING 06/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		428,383	419,178		238,547	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		40,985				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		469,368	419,178		238,547	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: 1900 STATE STREET P.O.BOX: 1
2 CITY: CHESTER STATE: IL ZIP CODE: 62233 COUNTY: RANDOLPH 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	MEMORIAL HOSPITAL	14-1338	99914	1	09/01/2004	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	MEMORIAL HOSPITAL-SWING BEDS	14-Z338	99914		09/01/2004	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		8							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.	3	N	23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							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 THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N	N	39

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

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

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

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

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

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

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

61.20

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63

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

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

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

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

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

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

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

INPATIENT PSYCHIATRIC FACILITY PPS

70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		71

INPATIENT REHABILITATION FACILITY PPS

75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.		76

LONG TERM CARE HOSPITAL PPS

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

TEFRA PROVIDERS

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

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

		V	XIX	
TITLE V AND XIX INPATIENT SERVICES		1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	Y	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.	N		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.	Y	Y	N	N	109

MISCELLANEOUS COST REPORTING INFORMATION			
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1	118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 136,680 PAID LOSSES: SELF INSURANCE:		118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121

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

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

ALL PROVIDERS

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

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

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:		141
142	STREET:	P.O. BOX:			142
143	CITY:	STATE:	ZIP CODE:		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?			Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.			N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.			N	149

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

MULTICAMPUS

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

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.		168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.		169
170	IF LINE 167 IS 'Y', ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD, RESPECTIVELY. (mmddyyyy) (SEE INSTRUCTIONS)		170

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

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N 1	TYPE 2	DATE 3	
	FINANCIAL DATA AND REPORTS				
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	11/30/2013	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)	N		N		16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	11/05/2013	Y	11/05/2013	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

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

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

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

	CAPITAL RELATED COST		
22	HAVE ASSETS BEEN RELIFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	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.	Y	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	Y	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	DATE	
	HOME OFFICE COSTS	1	2	
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: RAJ	LAST NAME: SHAH	TITLE: SR. CONSULTANT	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC.			42
43	PHONE NUMBER: 630-530-7100 X 107	E-MAIL ADDRESS: RAJ.SHAH@SRINC.ORG		43

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

	COMPONENT	WKST A LINE NO. 1	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	25	9,125	37,800.00		1,077	92	1,575	1
2	HMO AND OTHER (SEE INSTRUCTIONS)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						127		149	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	37,800.00		1,204	92	1,724	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	37,800.00		1,204	92	1,724	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)		25							27
28	OBSERVATION BED DAYS								350	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS --- TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES --- TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30					313	27	465	1
2	HMO AND OTHER (SEE INSTRUCTIONS)									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)			167.56			313	27	465	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
24.10	HOSPICE (NON-DISTINCT PART)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	TOTAL (SUM OF LINES 14-26)			167.56						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (SEE INSTR.)									32.01
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PART II & III

PART II - WAGE DATA

		WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
		1	2	3	4	5	6	
	SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	7,919,780			348,533.00		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)		18,955	19,948		2,873.00		10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)		449,016			11,724.00		11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE		453,608			3,028.00		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)		2,378,722					17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS		11,742					19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT		148,277			6,277.00		26
27	ADMINISTRATIVE & GENERAL		1,394,170			55,044.00		27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		80,850			534.00		28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT		356,690			15,040.00		30
31	LAUNDRY & LINEN SERVICE		53,759			3,739.00		31
32	HOUSEKEEPING		247,219			21,513.00		32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY		316,056	-202,984		9,543.00		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		30,494			587.00		35
36	CAFETERIA			183,036		15,445.00		36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION		310,014			10,560.00		38
39	CENTRAL SERVICES AND SUPPLY		51,830			3,830.00		39
40	PHARMACY		290,157			7,715.00		40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		359,010			20,462.00		41
42	SOCIAL SERVICE		69,184			3,269.00		42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	8,031,124		8,031,124	349,654.00	22.97	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	18,955	19,948	38,903	2,873.00	13.54	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	8,012,169	-19,948	7,992,221	346,781.00	23.05	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	902,624		902,624	14,752.00	61.19	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,378,722		2,378,722		29.76%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	11,293,515	-19,948	11,273,567	361,533.00	31.18	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,707,710	-19,948	3,687,762	173,558.00	21.25	7

HOSPITAL WAGE RELATED COSTS — WORKSHEET S-3 PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	663,027	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
	PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5	401K/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,018,009	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)	1,788	12
13	DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	-2,257	13
14	LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15	WORKERS' COMPENSATION INSURANCE	104,378	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	565,531	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES	1,270	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	38,718	23
24	TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,390,464	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	449,016	2,390,464	1
2	HOSPITAL	449,016	2,390,464	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		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)	0.578591	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	854,377	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	3,010,804	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	1,742,024	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.	887,647	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)	887,647	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	286,676	55,955	342,631	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	165,868	32,375	198,243	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			0	22
23	COST OF CHARITY CARE	165,868	32,375	198,243	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGHTH OF STAY LIMIT (SEE INSTRUCTIONS)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)	2,444,349	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	326,882	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	2,117,467	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	1,225,147	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	1,423,390	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	2,311,037	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI-CATIONS 4	
		GENERAL SERVICE COST CENTERS					
1	00100	CAP REL COSTS-BLDG & FIXT		1,510,574	1,510,574	-1,024,271	1
2	00200	CAP REL COSTS-MVBLE EQUIP				1,200,476	2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	148,277	2,402,563	2,550,840		4
5.01	00501	COMMUNICATIONS	44,537	66,416	110,953		5.01
5.02	00502	DATA PROCESSING	206,785	255,981	462,766		5.02
5.03	00503	PURCHASING	62,010	25,089	87,099		5.03
5.04	00504	ADMITTING	135,736	9,514	145,250		5.04
5.05	00505	CREDIT AND COLLECTIONS	154,148	95,702	249,850		5.05
5.06	00506	OTHER ADMINISTRATIVE & GENERAL	790,954	639,459	1,430,413	-53,813	5.06
6	00600	MAINTENANCE & REPAIRS					6
7	00700	OPERATION OF PLANT	356,690	465,111	821,801		7
8	00800	LAUNDRY & LINEN SERVICE	53,759	55,513	109,272		8
9	00900	HOUSEKEEPING	247,219	45,832	293,051		9
10	01000	DIETARY	316,056	208,024	524,080	-336,586	10
11	01100	CAFETERIA				303,508	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	310,014	4,381	314,395		13
14	01400	CENTRAL SERVICES & SUPPLY	51,830	544,934	596,764	-541,050	14
15	01500	PHARMACY	290,157	529,931	820,088	-341,977	15
16	01600	MEDICAL RECORDS & LIBRARY	359,010	77,660	436,670		16
17	01700	SOCIAL SERVICE	69,184	8,183	77,367		17
19	01900	NONPHYSICIAN ANESTHETISTS					19
20	02000	NURSING SCHOOL					20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	02300	PARAMED ED PRGM-(SPECIFY)					23
		INPATIENT ROUTINE SERV COST CENTERS					
30	03000	ADULTS & PEDIATRICS	1,519,409	63,619	1,583,028		30
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	521,631	581,835	1,103,466	-66,000	50
54	05400	RADIOLOGY-DIAGNOSTIC	718,037	497,440	1,215,477	-900	54
60	06000	LABORATORY	600,531	685,181	1,285,712	-14,362	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	28,651	114,253	142,904		62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	261,871	53,334	315,205	-720	65
66	06600	PHYSICAL THERAPY		424,639	424,639	-315	66
67	06700	OCCUPATIONAL THERAPY		18,152	18,152		67
68	06800	SPEECH PATHOLOGY		41,824	41,824		68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				319,971	71
71.01	07101	IMPLANTABLE SUPPLIES					71.01
71.02	07102	PACEMAKERS					71.02
72	07200	IMPL. DEV. CHARGED TO PATIENTS				221,079	72
73	07300	DRUGS CHARGED TO PATIENTS				301,882	73
74	07400	RENAL DIALYSIS					74
76	03950	CARDIAC REHAB		28,346	28,346	-28,346	76
76.01	03951	CHEMOTHERAPY	147,345	768,544	915,889		76.01
76.97	07697	CARDIAC REHABILITATION					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
90	09000	CLINIC	114,037	12,089	126,126		90
91	09100	EMERGENCY	392,947	1,301,708	1,694,655		91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92
		OTHER REIMBURSABLE COST CENTERS					
94	09400	HOME PROGRAM DIALYSIS					94
		SPECIAL PURPOSE COST CENTERS					
118		SUBTOTALS (SUM OF LINES 1-117)	7,900,825	11,535,831	19,436,656	-61,424	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,532		5,532		190
192	19200	PHYSICIANS' PRIVATE OFFICES	13,423	1,878	15,301		192
193.01	19301	CARDIAC REHAB				28,346	193.01
194	07950	NON-ALLOWABLE COSTS				33,078	194
200		TOTAL (SUM OF LINES 118-199)	7,919,780	11,537,709	19,457,489		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	486,303		486,303	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,200,476		1,200,476	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	2,550,840	61,929	2,612,769	4
5.01	00501	COMMUNICATIONS	110,953	-5,518	105,435	5.01
5.02	00502	DATA PROCESSING	462,766	-4,050	458,716	5.02
5.03	00503	PURCHASING	87,099		87,099	5.03
5.04	00504	ADMITTING	145,250		145,250	5.04
5.05	00505	CREDIT AND COLLECTIONS	249,850		249,850	5.05
5.06	00506	OTHER ADMINISTRATIVE & GENERAL	1,376,600	-292,015	1,084,585	5.06
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	821,801	-3,434	818,367	7
8	00800	LAUNDRY & LINEN SERVICE	109,272		109,272	8
9	00900	HOUSEKEEPING	293,051		293,051	9
10	01000	DIETARY	187,494		187,494	10
11	01100	CAFETERIA	303,508	-56,701	246,807	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	314,395		314,395	13
14	01400	CENTRAL SERVICES & SUPPLY	55,714		55,714	14
15	01500	PHARMACY	478,111		478,111	15
16	01600	MEDICAL RECORDS & LIBRARY	436,670	-2,016	434,654	16
17	01700	SOCIAL SERVICE	77,367		77,367	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
		INPATIENT ROUTINE SERV COST CENTERS				
30	03000	ADULTS & PEDIATRICS	1,583,028		1,583,028	30
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,037,466	-402,500	634,966	50
54	05400	RADIOLOGY-DIAGNOSTIC	1,214,577	-2,500	1,212,077	54
60	06000	LABORATORY	1,271,350		1,271,350	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	142,904		142,904	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	314,485	-7,257	307,228	65
66	06600	PHYSICAL THERAPY	424,324		424,324	66
67	06700	OCCUPATIONAL THERAPY	18,152		18,152	67
68	06800	SPEECH PATHOLOGY	41,824		41,824	68
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,971	-85	319,886	71
71.01	07101	IMPLANTABLE SUPPLIES				71.01
71.02	07102	PACEMAKERS				71.02
72	07200	IMPL. DEV. CHARGED TO PATIENTS	221,079		221,079	72
73	07300	DRUGS CHARGED TO PATIENTS	301,882	-49,281	252,601	73
74	07400	RENAL DIALYSIS				74
76	03950	CARDIAC REHAB				76
76.01	03951	CHEMOTHERAPY	915,889	-84,997	830,892	76.01
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
90	09000	CLINIC	126,126		126,126	90
91	09100	EMERGENCY	1,694,655	-843,245	851,410	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92
		OTHER REIMBURSABLE COST CENTERS				
94	09400	HOME PROGRAM DIALYSIS				94
		SPECIAL PURPOSE COST CENTERS				
118		SUBTOTALS (SUM OF LINES 1-117)	19,375,232	-1,691,670	17,683,562	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,532		5,532	190
192	19200	PHYSICIANS' PRIVATE OFFICES	15,301		15,301	192
193.01	19301	CARDIAC REHAB	28,346		28,346	193.01
194	07950	NON-ALLOWABLE COSTS	33,078		33,078	194
200		TOTAL (SUM OF LINES 118-199)	19,457,489	-1,691,670	17,765,819	200

RECLASSIFICATIONS — WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS DRUG COST	A	DRUGS CHARGED TO PATIENTS	73		270,815	1
500	TOTAL RECLASSIFICATIONS					270,815	500
	CODE LETTER - A						
1	RECLASS DEPRECIATION	B	CAP REL COSTS-MVBLE EQUIP	2		1,074,470	1
500	TOTAL RECLASSIFICATIONS					1,074,470	500
	CODE LETTER - B						
1	RECLASS MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		319,971	1
2	RECLASS MEDICAL SUPPLIES	C	IMPL. DEV. CHARGED TO PATIENT	72		221,079	2
500	TOTAL RECLASSIFICATIONS					541,050	500
	CODE LETTER - C						
1	RECLASS IV THERAPY	D	DRUGS CHARGED TO PATIENTS	73		31,067	1
500	TOTAL RECLASSIFICATIONS					31,067	500
	CODE LETTER - D						
1	CARDIAC REHAB	E	CARDIAC REHAB	193.01		28,346	1
500	TOTAL RECLASSIFICATIONS					28,346	500
	CODE LETTER - E						
1	CAFETRIA	F	CAFETERIA	11	183,036	120,472	1
2	NON ALLOWABLE MEALS	F	NON-ALLOWABLE COSTS	194	19,948	13,130	2
500	TOTAL RECLASSIFICATIONS				202,984	133,602	500
	CODE LETTER - F						
1	LEASE/RENTAL	H	CAP REL COSTS-MVBLE EQUIP	2		126,006	1
2							2
3							3
4							4
5							5
6							6
7							7
500	TOTAL RECLASSIFICATIONS					126,006	500
	CODE LETTER - H						
1	RECLASS PROPERTY INSURANCE	L	CAP REL COSTS-BLDG & FIXT	1		50,199	1
500	TOTAL RECLASSIFICATIONS					50,199	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				202,984	2,255,555	

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RECLASS DRUG COST	A	PHARMACY	15		270,815		1
500	TOTAL RECLASSIFICATIONS					270,815		500
	CODE LETTER - A							
1	RECLASS DEPRECIATION	B	CAP REL COSTS-BLDG & FIXT	1		1,074,470	9	1
500	TOTAL RECLASSIFICATIONS					1,074,470		500
	CODE LETTER - B							
1	RECLASS MEDICAL SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		541,050		1
2	RECLASS MEDICAL SUPPLIES	C						2
500	TOTAL RECLASSIFICATIONS					541,050		500
	CODE LETTER - C							
1	RECLASS IV THERAPY	D	PHARMACY	15		31,067		1
500	TOTAL RECLASSIFICATIONS					31,067		500
	CODE LETTER - D							
1	CARDIAC REHAB	E	CARDIAC REHAB	76		28,346		1
500	TOTAL RECLASSIFICATIONS					28,346		500
	CODE LETTER - E							
1	CAFETRIA	F	DIETARY	10	183,036	120,472		1
2	NON ALLOWABLE MEALS	F	DIETARY	10	19,948	13,130		2
500	TOTAL RECLASSIFICATIONS				202,984	133,602		500
	CODE LETTER - F							
1	LEASE/RENTAL	H	OTHER ADMINISTRATIVE & GENERA	5.06		3,614	10	1
2			PHARMACY	15		40,095	10	2
3			OPERATING ROOM	50		66,000	10	3
4			RADIOLOGY-DIAGNOSTIC	54		900	10	4
5			LABORATORY	60		14,362	10	5
6			RESPIRATORY THERAPY	65		720	10	6
7			PHYSICAL THERAPY	66		315	10	7
500	TOTAL RECLASSIFICATIONS					126,006		500
	CODE LETTER - H							
1	RECLASS PROPERTY INSURANCE	L	OTHER ADMINISTRATIVE & GENERA	5.06		50,199	12	1
500	TOTAL RECLASSIFICATIONS					50,199		500
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				202,984	2,255,555		

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	239,745				2,305	237,440		1
2	LAND IMPROVEMENTS	464,184	37,682		37,682		501,866		2
3	BUILDINGS AND FIXTURES	13,980,345	446,269		446,269		14,426,614		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	894,956	8,026		8,026		902,982		5
6	MOVABLE EQUIPMENT	11,498,892	172,817		172,817		11,671,709		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	27,078,122	664,794		664,794	2,305	27,740,611		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	27,078,122	664,794		664,794	2,305	27,740,611		10

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

	DESCRIPTION	SUMMARY OF CAPITAL DEPREC-IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) 14	TOTAL(1) (SUM OF COLS. 9-14) 15	
1	CAP REL COSTS-BLDG & FIXT	1,510,574						1,510,574	1
2	CAP REL COSTS-MVBLE EQUIP								2
3	TOTAL (SUM OF LINES 1-2)	1,510,574						1,510,574	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	15,831,463		15,831,463	0.575623					1
2	CAP REL COSTS-MVBLE EQUIP	11,671,709		11,671,709	0.424377					2
3	TOTAL (SUM OF LINES 1-2)	27,503,172		27,503,172	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	436,104			50,199			486,303	1
2	CAP REL COSTS-MVBLE EQUIP	1,074,470	126,006					1,200,476	2
3	TOTAL	1,510,574	126,006		50,199			1,686,779	3

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1	
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2	
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					3	
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-1,365	OTHER ADMINISTRATIVE & GENERAL	5.06	4	
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5	
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6	
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-5,518	COMMUNICATIONS	5.01	7	
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8	
9	PARKING LOT (CHAPTER 21)					9	
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-945,698			10	
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-3,434	OPERATION OF PLANT	7	11	
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12	
13	LAUNDRY AND LINEN SERVICE					13	
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-56,701	CAFETERIA	11	14	
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15	
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-85	MEDICAL SUPPLIES CHARGED TO PAT	71	16	
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17	
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2,016	MEDICAL RECORDS & LIBRARY	16	18	
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19	
20	VENDING MACHINES					20	
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21	
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22	
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23	
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24	
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25	
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26	
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27	
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28	
29	PHYSICIANS' ASSISTANT					29	
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30	
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31	
32	CAH HIT ADJ FOR DEPRECIATION AND					32	
33						33	
34						34	
35						35	
35.50	REBATES	A	-49,281	DRUGS CHARGED TO PATIENTS	73	35.50	
36	ORGANIZATION COST	A	-300	OTHER ADMINISTRATIVE & GENERAL	5.06	36	
36.01	CRNA FEES	A	-402,500	OPERATING ROOM	50	36.01	
36.03	ADMINISTRATIVE & GENERAL - MISC	B	-567	OTHER ADMINISTRATIVE & GENERAL	5.06	36.03	
37						37	
38	NON ALLOWABLE SALARIES	A	-17,588	OTHER ADMINISTRATIVE & GENERAL	5.06	38	
39	NON ALLOWABLE OTHER	A	-111,216	OTHER ADMINISTRATIVE & GENERAL	5.06	39	
40	CRNA AND MD BILLING EXPENSE	A	-119,960	OTHER ADMINISTRATIVE & GENERAL	5.06	40	
41						41	
42						42	
43	MISC INC ANALYSIS 5010-0220	B	-41,019	OTHER ADMINISTRATIVE & GENERAL	5.06	43	
44	MED TECH FEES FROM CMG	B	-4,050	DATA PROCESSING	5.02	44	
45						45	
45.02	MISC REV PET SCANNER	A	-2,500	RADIOLOGY-DIAGNOSTIC	54	45.02	
46	FINANCIAL AUDIT JE	A	10,199	CHEMOTHERAPY	76.01	46	
47	FINANCIAL AUDIT AJE	A	61,929	EMPLOYEE BENEFITS DEPARTMENT	4	47	
48						48	
49						49	
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-1,691,670			50	

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

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
2	60	LABORATORY	AGGREGATE	20,800		20,800					2
3	65	RESPIRATORY THERAPY	AGGREGATE	6,732	6,732						3
4	65	RESPIRATORY THERAPY	AGGREGATE	525	525						4
5	76.01	CHEMOTHERAPY	AGGREGATE	95,196	95,196						5
6	91	EMERGENCY	AGGREGATE	1,276,053	843,245	432,808					6
200		TOTAL		1,399,306	945,698	453,608					200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
2	60	LABORATORY	AGGREGATE								2
3	65	RESPIRATORY THERAPY	AGGREGATE							6,732	3
4	65	RESPIRATORY THERAPY	AGGREGATE							525	4
5	76.01	CHEMOTHERAPY	AGGREGATE							95,196	5
6	91	EMERGENCY	AGGREGATE							843,245	6
200		TOTAL								945,698	200

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS I & II

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED	1,500.53	1,057.82				9
10	AHSEA	70.63	70.63				10
11	STANDARD TRAVEL ALLOWANCE	35.32	35.32				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS	105,982	14
15	THERAPISTS	74,714	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	180,696	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	180,696	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	180,696	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS III & IV

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	180,696	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	180,696	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	18,152	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS I & II

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		4,191.93	4,885.52	2,434.09		9
10	AHSEA		74.53	55.90	37.27		10
11	STANDARD TRAVEL ALLOWANCE	37.27	37.27	27.95			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	312,425	15
16	ASSISTANTS	273,101	16
17	SUBTOTAL ALLOWANCE AMOUNT	585,526	17
18	AIDES	90,719	18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	676,245	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	676,245	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS III & IV

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29	THERAPISTS	29
30	ASSISTANTS	30
31	SUBTOTAL	31
32	OPTIONAL TRAVEL EXPENSE	32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE	
36	THERAPISTS	36
37	ASSISTANTS	37
38	SUBTOTAL	38
39	STANDARD TRAVEL EXPENSE	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
40	THERAPISTS	40
41	ASSISTANTS	41
42	SUBTOTAL	42
43	OPTIONAL TRAVEL EXPENSE	43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-3
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	676,245	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	676,245	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	417,335	64
65	EXCESS OVER LIMITATION		65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATION	
		0	1	2	4	5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	486,303	486,303				1
2	CAP REL COSTS-MVBLE EQUIP	1,200,476		1,200,476			2
4	EMPLOYEE BENEFITS DEPARTMENT	2,612,769	9,323	23,014	2,645,106		4
5.01	COMMUNICATIONS	105,435	620	1,530	15,159	122,744	5.01
5.02	DATA PROCESSING	458,716	4,813	11,882	70,381	3,091	5.02
5.03	PURCHASING	87,099	11,873	29,310	21,106	1,766	5.03
5.04	ADMITTING	145,250	1,693	4,179	46,199	1,325	5.04
5.05	CREDIT AND COLLECTIONS	249,850	11,126	27,466	52,466	3,974	5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	1,084,585	37,799	93,311	269,209	20,746	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	818,367	70,726	174,592	121,403	3,974	7
8	LAUNDRY & LINEN SERVICE	109,272	3,945	9,738	18,297	442	8
9	HOUSEKEEPING	293,051	7,093	17,509	84,143	442	9
10	DIETARY	187,494	6,053	14,942	38,485	2,208	10
11	CAFETERIA	246,807	10,153	25,062	62,298	442	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	314,395	9,300	22,959	105,516	3,974	13
14	CENTRAL SERVICES & SUPPLY	55,714	6,639	16,389	17,641	2,649	14
15	PHARMACY	478,111	6,191	15,283	98,758	2,208	15
16	MEDICAL RECORDS & LIBRARY	434,654	20,449	50,480	122,193	9,714	16
17	SOCIAL SERVICE	77,367	2,031	5,012	23,547	1,325	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,583,028	49,734	122,771	517,144	8,389	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	634,966	38,729	95,605	177,542	7,064	50
54	RADIOLOGY-DIAGNOSTIC	1,212,077	33,893	83,668	244,391	9,714	54
60	LABORATORY	1,271,350	13,610	33,598	204,397	6,181	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	142,904	797	1,967	9,752	442	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	307,228	9,489	23,423	89,130	4,415	65
66	PHYSICAL THERAPY	424,324	50,630	124,984		8,831	66
67	OCCUPATIONAL THERAPY	18,152	1,953	4,821			67
68	SPEECH PATHOLOGY	41,824				883	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	319,886					71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	221,079					72
73	DRUGS CHARGED TO PATIENTS	252,601					73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	830,892	13,516	33,366	50,150	1,766	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	126,126	14,036	34,650	38,814	8,831	90
91	EMERGENCY	851,410	25,937	64,028	133,743	4,857	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	17,683,562	472,151	1,165,539	2,631,864	119,653	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,532	4,952	12,224	1,883	883	190
192	PHYSICIANS' PRIVATE OFFICES	15,301	5,831	14,395	4,569	1,766	192
193.01	CARDIAC REHAB	28,346	3,369	8,318		442	193.01
194	NON-ALLOWABLE COSTS	33,078			6,790		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	17,765,819	486,303	1,200,476	2,645,106	122,744	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	DATA PROCESSING	PURCHASING	ADMITTING	CREDIT & COLLECTION	SUBTOTAL (COLS.0-4)	
		5.02	5.03	5.04	5.05	4A	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING	548,883					5.02
5.03	PURCHASING	881	152,035				5.03
5.04	ADMITTING	31,795	1,613	232,054			5.04
5.05	CREDIT AND COLLECTIONS	25,181	951		371,014		5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	19,204	5,987			1,530,841	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	865	7,480			1,197,407	7
8	LAUNDRY & LINEN SERVICE	20	118			141,832	8
9	HOUSEKEEPING	524	7,660			410,422	9
10	DIETARY	3,181	5,164			257,527	10
11	CAFETERIA					344,762	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	6,387	542			463,073	13
14	CENTRAL SERVICES & SUPPLY	1,042	654			100,728	14
15	PHARMACY	19,845	1,385			621,781	15
16	MEDICAL RECORDS & LIBRARY	79,252	2,062			718,804	16
17	SOCIAL SERVICE	8,758	187			118,227	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	106,075	6,775	16,124	25,777	2,435,817	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	35,877	12,273	16,525	26,419	1,045,000	50
54	RADIOLOGY-DIAGNOSTIC	8,712	10,624	57,180	91,443	1,751,702	54
60	LABORATORY	86,143	76,366	45,959	73,476	1,811,080	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,666	2,382	1,604	2,564	165,078	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	14,266	1,966	11,245	17,977	479,139	65
66	PHYSICAL THERAPY	5,308	871	12,493	19,973	647,414	66
67	OCCUPATIONAL THERAPY	198		534	854	26,512	67
68	SPEECH PATHOLOGY	159		724	1,158	44,748	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			26,600	42,525	389,011	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS			3,868	6,183	231,130	72
73	DRUGS CHARGED TO PATIENTS			10,078	16,112	278,791	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	14,378	834	14,860	23,756	983,518	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	18,932	1,990	2,359	3,771	249,509	90
91	EMERGENCY	55,991	3,976	11,901	19,026	1,170,869	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	545,640	151,860	232,054	371,014	17,614,722	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					25,474	190
192	PHYSICIANS' PRIVATE OFFICES	2,801	122			44,785	192
193.01	CARDIAC REHAB	442	53			40,970	193.01
194	NON-ALLOWABLE COSTS					39,868	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	548,883	152,035	232,054	371,014	17,765,819	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.06	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	1,530,841					5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	112,907	1,310,314				7
8	LAUNDRY & LINEN SERVICE	13,374	15,278	170,484			8
9	HOUSEKEEPING	38,700	27,470		476,592		9
10	DIETARY	24,283	23,442		8,814	314,066	10
11	CAFETERIA	32,509	39,319		14,784		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	43,665	36,020		13,543		13
14	CENTRAL SERVICES & SUPPLY	9,498	25,713		9,668		14
15	PHARMACY	58,630	23,977		9,015		15
16	MEDICAL RECORDS & LIBRARY	67,778	79,196		29,777		16
17	SOCIAL SERVICE	11,148	7,864		2,957		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	229,676	192,612	170,484	72,420	314,066	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	98,536	149,993		56,396		50
54	RADIOLOGY-DIAGNOSTIC	165,173	131,265		49,354		54
60	LABORATORY	170,772	52,712		19,819		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	15,566	3,086		1,160		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	45,179	36,748		13,817		65
66	PHYSICAL THERAPY	61,047	196,082		73,725		66
67	OCCUPATIONAL THERAPY	2,500	7,564		2,844		67
68	SPEECH PATHOLOGY	4,219					68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,681					71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	21,794					72
73	DRUGS CHARGED TO PATIENTS	26,288					73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	92,739	52,347		19,682		76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	23,527	54,362		20,439		90
91	EMERGENCY	110,405	100,452		37,769		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	1,516,594	1,255,502	170,484	455,983	314,066	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,402	19,178		7,211		190
192	PHYSICIANS' PRIVATE OFFICES	4,223	22,585		8,492		192
193.01	CARDIAC REHAB	3,863	13,049		4,906		193.01
194	NON-ALLOWABLE COSTS	3,759					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	1,530,841	1,310,314	170,484	476,592	314,066	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	
		11	13	14	15	16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	431,374					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	24,658	580,959				13
14	CENTRAL SERVICES & SUPPLY	4,122		149,729			14
15	PHARMACY	23,078			736,481		15
16	MEDICAL RECORDS & LIBRARY	28,555				924,110	16
17	SOCIAL SERVICE	5,503	15,164				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	120,849	333,035			64,207	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	41,489	114,335			65,804	50
54	RADIOLOGY-DIAGNOSTIC	57,111				227,742	54
60	LABORATORY	47,764				183,016	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,279				6,387	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	20,828				44,778	65
66	PHYSICAL THERAPY					49,749	66
67	OCCUPATIONAL THERAPY					2,128	67
68	SPEECH PATHOLOGY					2,884	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			88,548		105,923	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS			61,181		15,402	72
73	DRUGS CHARGED TO PATIENTS				229,142	40,133	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	11,719	32,296		507,339	59,172	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	9,070				9,394	90
91	EMERGENCY	31,254	86,129			47,391	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	428,279	580,959	149,729	736,481	924,110	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	440					190
192	PHYSICIANS' PRIVATE OFFICES	1,068					192
193.01	CARDIAC REHAB						193.01
194	NON-ALLOWABLE COSTS	1,587					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	431,374	580,959	149,729	736,481	924,110	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 DEPARTMENT					4
5.01	COMMUNICATIONS					5.01
5.02	DATA PROCESSING					5.02
5.03	PURCHASING					5.03
5.04	ADMITTING					5.04
5.05	CREDIT AND COLLECTIONS					5.05
5.06	OTHER ADMINISTRATIVE & GENERAL					5.06
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE	160,863				17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	160,863	4,094,029		4,094,029	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM		1,571,553		1,571,553	50
54	RADIOLOGY-DIAGNOSTIC		2,382,347		2,382,347	54
60	LABORATORY		2,285,163		2,285,163	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		193,556		193,556	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		640,489		640,489	65
66	PHYSICAL THERAPY		1,028,017		1,028,017	66
67	OCCUPATIONAL THERAPY		41,548		41,548	67
68	SPEECH PATHOLOGY		51,851		51,851	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		620,163		620,163	71
71.01	IMPLANTABLE SUPPLIES					71.01
71.02	PACEMAKERS					71.02
72	IMPL. DEV. CHARGED TO PATIENTS		329,507		329,507	72
73	DRUGS CHARGED TO PATIENTS		574,354		574,354	73
74	RENAL DIALYSIS					74
76	CARDIAC REHAB					76
76.01	CHEMOTHERAPY		1,758,812		1,758,812	76.01
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC		366,301		366,301	90
91	EMERGENCY		1,584,269		1,584,269	91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS					94
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	160,863	17,521,959		17,521,959	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		54,705		54,705	190
192	PHYSICIANS' PRIVATE OFFICES		81,153		81,153	192
193.01	CARDIAC REHAB		62,788		62,788	193.01
194	NON-ALLOWABLE COSTS		45,214		45,214	194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	160,863	17,765,819		17,765,819	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP-REL COSTS BLDG&FIXT 1	NEW CAP-REL COSTS MOV EQUIP 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		9,323	23,014	32,337	32,337	4
5.01	COMMUNICATIONS		620	1,530	2,150	185	5.01
5.02	DATA PROCESSING		4,813	11,882	16,695	860	5.02
5.03	PURCHASING		11,873	29,310	41,183	258	5.03
5.04	ADMITTING		1,693	4,179	5,872	565	5.04
5.05	CREDIT AND COLLECTIONS		11,126	27,466	38,592	641	5.05
5.06	OTHER ADMINISTRATIVE & GENERAL		37,799	93,311	131,110	3,291	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT		70,726	174,592	245,318	1,484	7
8	LAUNDRY & LINEN SERVICE		3,945	9,738	13,683	224	8
9	HOUSEKEEPING		7,093	17,509	24,602	1,029	9
10	DIETARY		6,053	14,942	20,995	470	10
11	CAFETERIA		10,153	25,062	35,215	762	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		9,300	22,959	32,259	1,290	13
14	CENTRAL SERVICES & SUPPLY		6,639	16,389	23,028	216	14
15	PHARMACY		6,191	15,283	21,474	1,207	15
16	MEDICAL RECORDS & LIBRARY		20,449	50,480	70,929	1,494	16
17	SOCIAL SERVICE		2,031	5,012	7,043	288	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		49,734	122,771	172,505	6,321	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		38,729	95,605	134,334	2,171	50
54	RADIOLOGY-DIAGNOSTIC		33,893	83,668	117,561	2,988	54
60	LABORATORY		13,610	33,598	47,208	2,499	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		797	1,967	2,764	119	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		9,489	23,423	32,912	1,090	65
66	PHYSICAL THERAPY		50,630	124,984	175,614		66
67	OCCUPATIONAL THERAPY		1,953	4,821	6,774		67
68	SPEECH PATHOLOGY						68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY		13,516	33,366	46,882	613	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC		14,036	34,650	48,686	475	90
91	EMERGENCY		25,937	64,028	89,965	1,635	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)		472,151	1,165,539	1,637,690	32,175	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,952	12,224	17,176	23	190
192	PHYSICIANS' PRIVATE OFFICES		5,831	14,395	20,226	56	192
193.01	CARDIAC REHAB		3,369	8,318	11,687		193.01
194	NON-ALLOWABLE COSTS					83	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)		486,303	1,200,476	1,686,779	32,337	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	COMMUNICATION	DATA PROCESSING	PURCHASING	ADMITTING	CREDIT & COLLECTION	
		5.01	5.02	5.03	5.04	5.05	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS	2,335					5.01
5.02	DATA PROCESSING	59	17,614				5.02
5.03	PURCHASING	34	28	41,503			5.03
5.04	ADMITTING	25	1,020	440	7,922		5.04
5.05	CREDIT AND COLLECTIONS	76	808	260		40,377	5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	394	616	1,634			5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	76	28	2,042			7
8	LAUNDRY & LINEN SERVICE	8	1	32			8
9	HOUSEKEEPING	8	17	2,091			9
10	DIETARY	42	102	1,410			10
11	CAFETERIA	8					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	76	205	148			13
14	CENTRAL SERVICES & SUPPLY	50	33	179			14
15	PHARMACY	42	637	378			15
16	MEDICAL RECORDS & LIBRARY	185	2,543	563			16
17	SOCIAL SERVICE	25	281	51			17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	160	3,405	1,850	551	2,805	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	134	1,151	3,350	565	2,875	50
54	RADIOLOGY-DIAGNOSTIC	185	280	2,900	1,944	9,957	54
60	LABORATORY	118	2,764	20,847	1,571	7,995	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	8	86	650	55	279	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	84	458	537	384	1,956	65
66	PHYSICAL THERAPY	168	170	238	427	2,173	66
67	OCCUPATIONAL THERAPY		6		18	93	67
68	SPEECH PATHOLOGY	17	5		25	126	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				909	4,627	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS				132	673	72
73	DRUGS CHARGED TO PATIENTS				345	1,753	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	34	461	228	508	2,585	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	168	608	543	81	410	90
91	EMERGENCY	92	1,797	1,085	407	2,070	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,276	17,510	41,456	7,922	40,377	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17					190
192	PHYSICIANS' PRIVATE OFFICES	34	90	33			192
193.01	CARDIAC REHAB	8	14	14			193.01
194	NON-ALLOWABLE COSTS						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	2,335	17,614	41,503	7,922	40,377	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	137,045					5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	10,107	259,055				7
8	LAUNDRY & LINEN SERVICE	1,197	3,020	18,165			8
9	HOUSEKEEPING	3,464	5,431		36,642		9
10	DIETARY	2,174	4,635		678	30,506	10
11	CAFETERIA	2,910	7,774		1,137		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,909	7,121		1,041		13
14	CENTRAL SERVICES & SUPPLY	850	5,084		743		14
15	PHARMACY	5,248	4,740		693		15
16	MEDICAL RECORDS & LIBRARY	6,067	15,657		2,289		16
17	SOCIAL SERVICE	998	1,555		227		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	20,568	38,080	18,165	5,568	30,506	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	8,821	29,654		4,336		50
54	RADIOLOGY-DIAGNOSTIC	14,786	25,952		3,795		54
60	LABORATORY	15,287	10,421		1,524		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,393	610		89		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	4,044	7,265		1,062		65
66	PHYSICAL THERAPY	5,465	38,767		5,669		66
67	OCCUPATIONAL THERAPY	224	1,495		219		67
68	SPEECH PATHOLOGY	378					68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,284					71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS	1,951					72
73	DRUGS CHARGED TO PATIENTS	2,353					73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	8,302	10,349		1,513		76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,106	10,748		1,571		90
91	EMERGENCY	9,883	19,860		2,904		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	135,769	248,218	18,165	35,058	30,506	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	215	3,792		554		190
192	PHYSICIANS' PRIVATE OFFICES	378	4,465		653		192
193.01	CARDIAC REHAB	346	2,580		377		193.01
194	NON-ALLOWABLE COSTS	337					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	137,045	259,055	18,165	36,642	30,506	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINI-STRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	
		11	13	14	15	16	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA	47,806					11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,733	48,782				13
14	CENTRAL SERVICES & SUPPLY	457		30,640			14
15	PHARMACY	2,558			36,977		15
16	MEDICAL RECORDS & LIBRARY	3,165				102,892	16
17	SOCIAL SERVICE	610	1,273				17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	13,390	27,964			7,150	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,598	9,601			7,328	50
54	RADIOLOGY-DIAGNOSTIC	6,329				25,348	54
60	LABORATORY	5,294				20,380	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	253				711	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,308				4,986	65
66	PHYSICAL THERAPY					5,540	66
67	OCCUPATIONAL THERAPY					237	67
68	SPEECH PATHOLOGY					321	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			18,120		11,795	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS			12,520		1,715	72
73	DRUGS CHARGED TO PATIENTS				11,505	4,469	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	1,299	2,712		25,472	6,589	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	1,005				1,046	90
91	EMERGENCY	3,464	7,232			5,277	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	47,463	48,782	30,640	36,977	102,892	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	49					190
192	PHYSICIANS' PRIVATE OFFICES	118					192
193.01	CARDIAC REHAB						193.01
194	NON-ALLOWABLE COSTS	176					194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	47,806	48,782	30,640	36,977	102,892	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B
PART II

	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 DEPARTMENT					4
5.01	COMMUNICATIONS					5.01
5.02	DATA PROCESSING					5.02
5.03	PURCHASING					5.03
5.04	ADMITTING					5.04
5.05	CREDIT AND COLLECTIONS					5.05
5.06	OTHER ADMINISTRATIVE & GENERAL					5.06
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE	12,351				17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	12,351	361,339		361,339	30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM		208,918		208,918	50
54	RADIOLOGY-DIAGNOSTIC		212,025		212,025	54
60	LABORATORY		135,908		135,908	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		7,017		7,017	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY		57,086		57,086	65
66	PHYSICAL THERAPY		234,231		234,231	66
67	OCCUPATIONAL THERAPY		9,066		9,066	67
68	SPEECH PATHOLOGY		872		872	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		38,735		38,735	71
71.01	IMPLANTABLE SUPPLIES					71.01
71.02	PACEMAKERS					71.02
72	IMPL. DEV. CHARGED TO PATIENTS		16,991		16,991	72
73	DRUGS CHARGED TO PATIENTS		20,425		20,425	73
74	RENAL DIALYSIS					74
76	CARDIAC REHAB					76
76.01	CHEMOTHERAPY		107,547		107,547	76.01
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	CLINIC		67,447		67,447	90
91	EMERGENCY		145,671		145,671	91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
94	HOME PROGRAM DIALYSIS					94
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (SUM OF LINES 1-117)	12,351	1,623,278		1,623,278	118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		21,826		21,826	190
192	PHYSICIANS' PRIVATE OFFICES		26,053		26,053	192
193.01	CARDIAC REHAB		15,026		15,026	193.01
194	NON-ALLOWABLE COSTS		596		596	194
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (SUM OF LINES 118-201)	12,351	1,686,779		1,686,779	202

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT SQ FEET 1	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	COMMUNICA-TION # NON PT. TELEPHONES 5.01	DATA PROCESSING TIME SPENT 5.02	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	87,896					1
2	CAP REL COSTS-MVBLE EQUIP		87,896				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,685	1,685	7,771,503			4
5.01	COMMUNICATIONS	112	112	44,537	278		5.01
5.02	DATA PROCESSING	870	870	206,785	7	1,714,347	5.02
5.03	PURCHASING	2,146	2,146	62,010	4	2,753	5.03
5.04	ADMITTING	306	306	135,736	3	99,306	5.04
5.05	CREDIT AND COLLECTIONS	2,011	2,011	154,148	9	78,648	5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	6,832	6,832	790,954	47	59,981	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	12,783	12,783	356,690	9	2,702	7
8	LAUNDRY & LINEN SERVICE	713	713	53,759	1	61	8
9	HOUSEKEEPING	1,282	1,282	247,219	1	1,638	9
10	DIETARY	1,094	1,094	113,072	5	9,936	10
11	CAFETERIA	1,835	1,835	183,036	1		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,681	1,681	310,014	9	19,948	13
14	CENTRAL SERVICES & SUPPLY	1,200	1,200	51,830	6	3,255	14
15	PHARMACY	1,119	1,119	290,157	5	61,982	15
16	MEDICAL RECORDS & LIBRARY	3,696	3,696	359,010	22	247,532	16
17	SOCIAL SERVICE	367	367	69,184	3	27,355	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,989	8,989	1,519,409	19	331,303	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	7,000	7,000	521,631	16	112,056	50
54	RADIOLOGY-DIAGNOSTIC	6,126	6,126	718,037	22	27,209	54
60	LABORATORY	2,460	2,460	600,531	14	269,054	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	144	144	28,651	1	8,327	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,715	1,715	261,871	10	44,559	65
66	PHYSICAL THERAPY	9,151	9,151		20	16,580	66
67	OCCUPATIONAL THERAPY	353	353			619	67
68	SPEECH PATHOLOGY				2	497	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,443	2,443	147,345	4	44,907	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,537	2,537	114,037	20	59,131	90
91	EMERGENCY	4,688	4,688	392,947	11	174,878	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	85,338	85,338	7,732,600	271	1,704,217	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	895	895	5,532	2		190
192	PHYSICIANS' PRIVATE OFFICES	1,054	1,054	13,423	4	8,750	192
193.01	CARDIAC REHAB	609	609		1	1,380	193.01
194	NON-ALLOWABLE COSTS			19,948			194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP-REL COSTS BLDG&FIXT SQ FEET 1	NEW CAP-REL COSTS MOV EQUIP SQUARE FEET 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	COMMUNICA-TION # NON PT. TELEPHONES 5.01	DATA PROCESSING TIME SPENT 5.02	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	486,303	1,200,476	2,645,106	122,744	548,883	202
203	UNIT COST MULT-WS B PT I	5.532709	13.657914	0.340360	441.525180	0.320170	203
204	COST TO BE ALLOC PER B PT II			32,337	2,335	17,614	204
205	UNIT COST MULT-WS B PT II			0.004161	8.399281	0.010274	205

COST ALLOCATION - STATISTICAL BASIS — WORKSHEET B-1

	COST CENTER DESCRIPTION	PURCHASING SUPPLY COS 5.03	ADMITTING GROSS REVENUE 5.04	CREDIT & COLLECTION GROSS REVENUE 5.05	RECON-CILIATION 5A.06	ADMINISTRATIVE & GENERAL ACCUM COST 5.06	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING	880,912					5.03
5.04	ADMITTING	9,348	30,283,859				5.04
5.05	CREDIT AND COLLECTIONS	5,513		30,283,859			5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	34,688			-1,530,841	16,234,978	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	43,338				1,197,407	7
8	LAUNDRY & LINEN SERVICE	684				141,832	8
9	HOUSEKEEPING	44,382				410,422	9
10	DIETARY	29,919				257,527	10
11	CAFETERIA					344,762	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	3,139				463,073	13
14	CENTRAL SERVICES & SUPPLY	3,790				100,728	14
15	PHARMACY	8,023				621,781	15
16	MEDICAL RECORDS & LIBRARY	11,947				718,804	16
17	SOCIAL SERVICE	1,084				118,227	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	39,258	2,104,103	2,104,103		2,435,817	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	71,114	2,156,437	2,156,437		1,045,000	50
54	RADIOLOGY-DIAGNOSTIC	61,555	7,463,396	7,463,396		1,751,702	54
60	LABORATORY	442,478	5,997,570	5,997,570		1,811,080	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	13,803	209,313	209,313		165,078	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	11,392	1,467,422	1,467,422		479,139	65
66	PHYSICAL THERAPY	5,045	1,630,309	1,630,309		647,414	66
67	OCCUPATIONAL THERAPY		69,720	69,720		26,512	67
68	SPEECH PATHOLOGY		94,498	94,498		44,748	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,471,175	3,471,175		389,011	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS		504,722	504,722		231,130	72
73	DRUGS CHARGED TO PATIENTS		1,315,173	1,315,173		278,791	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	4,833	1,939,125	1,939,125		983,518	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	11,530	307,842	307,842		249,509	90
91	EMERGENCY	23,038	1,553,054	1,553,054		1,170,869	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	879,901	30,283,859	30,283,859	-1,530,841	16,083,881	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					25,474	190
192	PHYSICIANS' PRIVATE OFFICES	704				44,785	192
193.01	CARDIAC REHAB	307				40,970	193.01
194	NON-ALLOWABLE COSTS					39,868	194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	PURCHASING SUPPLY COS 5.03	ADMITTING GROSS REVENUE 5.04	CREDIT & COLLECTION GROSS REVENUE 5.05	RECON- CILIATION 5A.06	ADMINISTRA TIVE & GENERAL ACCUM COST 5.06	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	152,035	232,054	371,014		1,530,841	202
203	UNIT COST MULT-WS B PT I	0.172588	0.007663	0.012251		0.094293	203
204	COST TO BE ALLOC PER B PT II	41,503	7,922	40,377		137,045	204
205	UNIT COST MULT-WS B PT II	0.047114	0.000262	0.001333		0.008441	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE PATIENT DAYS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY PATIENT DAYS 10	CAFETERIA GROSS SALARIES 11	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	61,151					7
8	LAUNDRY & LINEN SERVICE	713	1,575				8
9	HOUSEKEEPING	1,282		59,156			9
10	DIETARY	1,094		1,094	1,575		10
11	CAFETERIA	1,835		1,835		5,423,557	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,681		1,681		310,014	13
14	CENTRAL SERVICES & SUPPLY	1,200		1,200		51,830	14
15	PHARMACY	1,119		1,119		290,157	15
16	MEDICAL RECORDS & LIBRARY	3,696		3,696		359,010	16
17	SOCIAL SERVICE	367		367		69,184	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	8,989	1,575	8,989	1,575	1,519,409	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	7,000		7,000		521,631	50
54	RADIOLOGY-DIAGNOSTIC	6,126		6,126		718,037	54
60	LABORATORY	2,460		2,460		600,531	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	144		144		28,651	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,715		1,715		261,871	65
66	PHYSICAL THERAPY	9,151		9,151			66
67	OCCUPATIONAL THERAPY	353		353			67
68	SPEECH PATHOLOGY						68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	2,443		2,443		147,345	76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	2,537		2,537		114,037	90
91	EMERGENCY	4,688		4,688		392,947	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	58,593	1,575	56,598	1,575	5,384,654	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	895		895		5,532	190
192	PHYSICIANS' PRIVATE OFFICES	1,054		1,054		13,423	192
193.01	CARDIAC REHAB	609		609			193.01
194	NON-ALLOWABLE COSTS					19,948	194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 7	LAUNDRY AND LINEN SERVICE PATIENT DAYS 8	HOUSE-KEEPING SQUARE FEET 9	DIETARY PATIENT DAYS 10	CAFETERIA GROSS SALARIES 11	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,310,314	170,484	476,592	314,066	431,374	202
203	UNIT COST MULT-WS B PT I	21.427515	108.243810	8.056529	199.406984	0.079537	203
204	COST TO BE ALLOC PER B PT II	259,055	18,165	36,642	30,506	47,806	204
205	UNIT COST MULT-WS B PT II	4.236317	11.533333	0.619413	19.368889	0.008815	205

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINI-STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	
		13	14	15	16	17	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	2,650,516					13
14	CENTRAL SERVICES & SUPPLY		541,050				14
15	PHARMACY			970,272			15
16	MEDICAL RECORDS & LIBRARY				30,283,859		16
17	SOCIAL SERVICE	69,184				1,575	17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,519,409			2,104,103	1,575	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	521,631			2,156,437		50
54	RADIOLOGY-DIAGNOSTIC				7,463,396		54
60	LABORATORY				5,997,570		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				209,313		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY				1,467,422		65
66	PHYSICAL THERAPY				1,630,309		66
67	OCCUPATIONAL THERAPY				69,720		67
68	SPEECH PATHOLOGY				94,498		68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		319,971		3,471,175		71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS		221,079		504,722		72
73	DRUGS CHARGED TO PATIENTS			301,882	1,315,173		73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	147,345		668,390	1,939,125		76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC				307,842		90
91	EMERGENCY	392,947			1,553,054		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	2,650,516	541,050	970,272	30,283,859	1,575	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
193.01	CARDIAC REHAB						193.01
194	NON-ALLOWABLE COSTS						194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NURSING ADMINI-STRATION SALARIES	CENTRAL SERVICES & SUPPLY COSTED REQUIS	PHARMACY COSTED REQUIS	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	
		13	14	15	16	17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	580,959	149,729	736,481	924,110	160,863	202
203	UNIT COST MULT-WS B PT I	0.219187	0.276738	0.759046	0.030515	102.135238	203
204	COST TO BE ALLOC PER B PT II	48,782	30,640	36,977	102,892	12,351	204
205	UNIT COST MULT-WS B PT II	0.018405	0.056631	0.038110	0.003398	7.841905	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 DEPARTMENT	4
5.01	COMMUNICATIONS	5.01
5.02	DATA PROCESSING	5.02
5.03	PURCHASING	5.03
5.04	ADMITTING	5.04
5.05	CREDIT AND COLLECTIONS	5.05
5.06	OTHER ADMINISTRATIVE & GENERAL	5.06
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SERVICES-SALARY & FRINGES APPRVD	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
54	RADIOLOGY-DIAGNOSTIC	54
60	LABORATORY	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
67	OCCUPATIONAL THERAPY	67
68	SPEECH PATHOLOGY	68
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	71
71.01	IMPLANTABLE SUPPLIES	71.01
71.02	PACEMAKERS	71.02
72	IMPL. DEV. CHARGED TO PATIENTS	72
73	DRUGS CHARGED TO PATIENTS	73
74	RENAL DIALYSIS	74
76	CARDIAC REHAB	76
76.01	CHEMOTHERAPY	76.01
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
90	CLINIC	90
91	EMERGENCY	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	92
	OTHER REIMBURSABLE COST CENTERS	
94	HOME PROGRAM DIALYSIS	94
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
192	PHYSICIANS' PRIVATE OFFICES	192
193.01	CARDIAC REHAB	193.01
194	NON-ALLOWABLE COSTS	194

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
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	4,094,029		4,094,029			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,571,553		1,571,553			50
54	RADIOLOGY-DIAGNOSTIC	2,382,347		2,382,347			54
60	LABORATORY	2,285,163		2,285,163			60
62	WHOLE BLOOD & PACKED RED BL	193,556		193,556			62
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	640,489		640,489			65
66	PHYSICAL THERAPY	1,028,017		1,028,017			66
67	OCCUPATIONAL THERAPY	41,548		41,548			67
68	SPEECH PATHOLOGY	51,851		51,851			68
71	MEDICAL SUPPLIES CHARGED TO	620,163		620,163			71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIE	329,507		329,507			72
73	DRUGS CHARGED TO PATIENTS	574,354		574,354			73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	1,758,812		1,758,812			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	366,301		366,301			90
91	EMERGENCY	1,584,269		1,584,269			91
92	OBSERVATION BEDS (NON-DISTI	690,893		690,893			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	SUBTOTAL (SEE INSTRUCTIONS)	18,212,852		18,212,852			200
201	LESS OBSERVATION BEDS	690,893		690,893			201
202	TOTAL (SEE INSTRUCTIONS)	17,521,959		17,521,959			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	1,601,914		1,601,914				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	296,934	1,859,503	2,156,437	0.728773			50
54	RADIOLOGY-DIAGNOSTIC	297,067	7,166,329	7,463,396	0.319204			54
60	LABORATORY	775,488	5,222,082	5,997,570	0.381015			60
62	WHOLE BLOOD & PACKED RED BL	88,268	121,045	209,313	0.924720			62
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	381,011	1,086,411	1,467,422	0.436472			65
66	PHYSICAL THERAPY	153,557	1,476,752	1,630,309	0.630566			66
67	OCCUPATIONAL THERAPY	13,880	55,840	69,720	0.595927			67
68	SPEECH PATHOLOGY	23,631	70,867	94,498	0.548699			68
71	MEDICAL SUPPLIES CHARGED TO	896,343	2,574,832	3,471,175	0.178661			71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIE	348,348	156,374	504,722	0.652848			72
73	DRUGS CHARGED TO PATIENTS	455,568	859,605	1,315,173	0.436714			73
74	RENAL DIALYSIS							74
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY	154,416	1,784,709	1,939,125	0.907013			76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		307,842	307,842	1.189899			90
91	EMERGENCY	3,000	1,550,054	1,553,054	1.020099			91
92	OBSERVATION BEDS (NON-DISTI		502,189	502,189	1.375763			92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	SUBTOTAL (SEE INSTRUCTIONS)	5,489,425	24,794,434	30,283,859				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		24,794,434	30,283,859				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1338)	[ ]	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	0.728773		832,635			606,802		50
54	RADIOLOGY-DIAGNOSTIC	0.319204		2,798,402			893,261		54
60	LABORATORY	0.381015		2,364,991			901,097		60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720		71,672			66,277		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.436472		519,984			226,958		65
66	PHYSICAL THERAPY	0.630566		663,277			418,240		66
67	OCCUPATIONAL THERAPY	0.595927		21,750			12,961		67
68	SPEECH PATHOLOGY	0.548699		34,520			18,941		68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661		1,152,736			205,949		71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848		94,888			61,947		72
73	DRUGS CHARGED TO PATIENTS	0.436714		435,049			189,992		73
74	RENAL DIALYSIS								74
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	0.907013		1,118,627	6,522		1,014,609	5,916	76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.189899		169,897			202,160		90
91	EMERGENCY	1.020099		582,296	2,044		594,000	2,085	91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763		304,211			418,522		92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)			11,164,935	8,566		5,831,716	8,001	200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			11,164,935	8,566		5,831,716	8,001	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-Z338)
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	0.728773							50
54	RADIOLOGY-DIAGNOSTIC	0.319204							54
60	LABORATORY	0.381015							60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.436472							65
66	PHYSICAL THERAPY	0.630566							66
67	OCCUPATIONAL THERAPY	0.595927							67
68	SPEECH PATHOLOGY	0.548699							68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661							71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848							72
73	DRUGS CHARGED TO PATIENTS	0.436714							73
74	RENAL DIALYSIS								74
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	0.907013							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.189899							90
91	EMERGENCY	1.020099							91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

CHECK [ ] TITLE V
APPLICABLE [ ] TITLE XVIII-PT A
BOXES [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	361,339	25,959	335,380	1,925	174.22	92	16,028	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)	361,339		335,380	1,925		92	16,028	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	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	208,918	2,156,437	0.096881	26,376	2,555	50
54	RADIOLOGY-DIAGNOSTIC	212,025	7,463,396	0.028409	28,177	800	54
60	LABORATORY	135,908	5,997,570	0.022661	62,887	1,425	60
62	WHOLE BLOOD & PACKED RED BLOO	7,017	209,313	0.033524	14,569	488	62
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	57,086	1,467,422	0.038902	21,190	824	65
66	PHYSICAL THERAPY	234,231	1,630,309	0.143673	2,883	414	66
67	OCCUPATIONAL THERAPY	9,066	69,720	0.130034			67
68	SPEECH PATHOLOGY	872	94,498	0.009228			68
71	MEDICAL SUPPLIES CHARGED TO P	38,735	3,471,175	0.011159	70,824	790	71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENT	16,991	504,722	0.033664			72
73	DRUGS CHARGED TO PATIENTS	20,425	1,315,173	0.015530	38,894	604	73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY	107,547	1,939,125	0.055462			76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC	67,447	307,842	0.219096			90
91	EMERGENCY	145,671	1,553,054	0.093796	119	11	91
92	OBSERVATION BEDS (NON-DISTINC	65,698	502,189	0.130823			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,327,637	28,681,945		265,919	7,911	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	1,925		92		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)	1,925		92		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	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
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOO							62
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
71	MEDICAL SUPPLIES CHARGED TO P							71
71.01	IMPLANTABLE SUPPLIES							71.01
71.02	PACEMAKERS							71.02
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76	CARDIAC REHAB							76
76.01	CHEMOTHERAPY							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	CLINIC							90
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINC							92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	TOTAL (SUM OF LINES 50-199)							200

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2,156,437			26,376				50
54	RADIOLOGY-DIAGNOSTIC	7,463,396			28,177				54
60	LABORATORY	5,997,570			62,887				60
62	WHOLE BLOOD & PACKED RED BLO	209,313			14,569				62
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	1,467,422			21,190				65
66	PHYSICAL THERAPY	1,630,309			2,883				66
67	OCCUPATIONAL THERAPY	69,720							67
68	SPEECH PATHOLOGY	94,498							68
71	MEDICAL SUPPLIES CHARGED TO	3,471,175			70,824				71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIEN	504,722							72
73	DRUGS CHARGED TO PATIENTS	1,315,173			38,894				73
74	RENAL DIALYSIS								74
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	1,939,125							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	307,842							90
91	EMERGENCY	1,553,054			119				91
92	OBSERVATION BEDS (NON-DISTIN	502,189							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	28,681,945			265,919				200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1338)	[ ]	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	0.728773							50
54	RADIOLOGY-DIAGNOSTIC	0.319204							54
60	LABORATORY	0.381015							60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.436472							65
66	PHYSICAL THERAPY	0.630566							66
67	OCCUPATIONAL THERAPY	0.595927							67
68	SPEECH PATHOLOGY	0.548699							68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661							71
71.01	IMPLANTABLE SUPPLIES								71.01
71.02	PACEMAKERS								71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848							72
73	DRUGS CHARGED TO PATIENTS	0.436714							73
74	RENAL DIALYSIS								74
76	CARDIAC REHAB								76
76.01	CHEMOTHERAPY	0.907013							76.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	CLINIC	1.189899							90
91	EMERGENCY	1.020099							91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART I

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1338)	[ ]	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)	2,074	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,925	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,575	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	74	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)	75	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)	1,077	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)	63	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)	64	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,094,029	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)	294,123	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,799,906	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,799,906	37

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

CHECK APPLICABLE BOXES	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1338)	[ ]	SUB (OTHER)	[ ] PPS
	[XX]	TITLE XVIII-PT A	[ ]	IPF			[ ] TEFRA
	[ ]	TITLE XIX-INPT	[ ]	IRF			[XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)	1,973.98	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,125,976	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40)	2,125,976	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)					1,013,432	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,139,408	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)					124,361	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					126,335	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					250,696	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)	350	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	1,973.98	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	690,893	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	361,339	3,799,906	0.095092	690,893	65,698	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 (14-1338)	[ ]	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)	2,074	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,925	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,575	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	74	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)	75	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)	92	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,094,029	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)	294,123	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,799,906	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)		28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,799,906	37

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

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1338)	[ ]	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)	1,973.98	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	181,606	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)	181,606	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)					106,476	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					288,082	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					16,028	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV)					7,911	51
52	TOTAL PROGRAM EXCLUDABLE COST					23,939	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)	350	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 (14-1338)	[ ]	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		883,689		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.728773	170,962	124,592	50
54	RADIOLOGY-DIAGNOSTIC	0.319204	204,375	65,237	54
60	LABORATORY	0.381015	514,154	195,900	60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720	45,153	41,754	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.436472	275,379	120,195	65
66	PHYSICAL THERAPY	0.630566	73,845	46,564	66
67	OCCUPATIONAL THERAPY	0.595927	3,352	1,998	67
68	SPEECH PATHOLOGY	0.548699	16,415	9,007	68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661	549,651	98,201	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848	217,987	142,312	72
73	DRUGS CHARGED TO PATIENTS	0.436714	374,128	163,387	73
74	RENAL DIALYSIS				74
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	0.907013	1,862	1,689	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.189899			90
91	EMERGENCY	1.020099	2,545	2,596	91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		2,449,808	1,013,432	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		2,449,808		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z338)	[ ]	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	0.728773			50
54	RADIOLOGY-DIAGNOSTIC	0.319204	4,051	1,293	54
60	LABORATORY	0.381015	21,657	8,252	60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720	1,982	1,833	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.436472	13,596	5,934	65
66	PHYSICAL THERAPY	0.630566	47,404	29,891	66
67	OCCUPATIONAL THERAPY	0.595927	7,161	4,267	67
68	SPEECH PATHOLOGY	0.548699	5,045	2,768	68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661	17,904	3,199	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848			72
73	DRUGS CHARGED TO PATIENTS	0.436714	18,605	8,125	73
74	RENAL DIALYSIS				74
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	0.907013	754	684	76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.189899			90
91	EMERGENCY	1.020099			91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		138,159	66,246	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		138,159		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	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		75,296		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.728773	26,376	19,222	50
54	RADIOLOGY-DIAGNOSTIC	0.319204	28,177	8,994	54
60	LABORATORY	0.381015	62,887	23,961	60
62	WHOLE BLOOD & PACKED RED BLOOD	0.924720	14,569	13,472	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.436472	21,190	9,249	65
66	PHYSICAL THERAPY	0.630566	2,883	1,818	66
67	OCCUPATIONAL THERAPY	0.595927			67
68	SPEECH PATHOLOGY	0.548699			68
71	MEDICAL SUPPLIES CHARGED TO PAT	0.178661	70,824	12,653	71
71.01	IMPLANTABLE SUPPLIES				71.01
71.02	PACEMAKERS				71.02
72	IMPL. DEV. CHARGED TO PATIENTS	0.652848			72
73	DRUGS CHARGED TO PATIENTS	0.436714	38,894	16,986	73
74	RENAL DIALYSIS				74
76	CARDIAC REHAB				76
76.01	CHEMOTHERAPY	0.907013			76.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	CLINIC	1.189899			90
91	EMERGENCY	1.020099	119	121	91
92	OBSERVATION BEDS (NON-DISTINCT	1.375763			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		265,919	106,476	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		265,919		202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1338) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,839,717	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)	5,839,717	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)	5,898,114	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)	31,858	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	1,756,376	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	4,109,880	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)	4,109,880	30
31	PRIMARY PAYER PAYMENTS	249	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	4,109,631	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)	277,955	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	277,955	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	245,288	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	4,387,586	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (UESTRATION)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	4,387,586	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	21,938	40.01
41	INTERIM PAYMENTS	3,946,470	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	419,178	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 (14-1338) [ ] 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				2,496,736		3,946,470	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	02/13/2013	8,823		NONE	3.01
		.02	04/29/2013	17,565			3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99		26,388			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)				2,523,124		3,946,470	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		443,215		441,116	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				2,966,339		4,387,586	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 [XX] SUB (OTHER) [ ] SNF SWING BED SNF (14-Z338)

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				273,865			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					
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50		NONE		NONE	3.50
		.51					3.51
	PROVIDER TO PROGRAM	.52					3.52
		.53					3.53
		.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99					3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)				273,865			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		42,567			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				316,432			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 (14-1338) [ ] 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	465	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,077	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,575	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	30,283,859	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	342,631	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (SEE INSTRUCTIONS)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 (OR LINE 10) MINUS LINE 30 AND LINE 31) (SEE INSTRUCTIONS)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS WORKSHEET E-2

CHECK APPLICABLE BOXES
[ ] TITLE V
[XX] TITLE XVIII
[ ] TITLE XIX
[XX] SWING BED - SNF (14-Z338)
[ ] SWING BED - NF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	253,203		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)	66,908		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	127		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)	320,111		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	320,111		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	320,111		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	3,679		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)	316,432		15
16	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			16
17	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			18
19	TOTAL (SEE INSTRUCTIONS)	316,432		19
19.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,582		19.01
20	INTERIM PAYMENTS	273,865		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	40,985		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1338)
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	3,139,408	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,139,408	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,170,802	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)	3,170,802	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	250,500	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	2,920,302	22
23	COINSURANCE	2,890	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,917,412	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	48,927	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	48,927	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	41,347	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	2,966,339	28
29	OTHER ADJUSTMENTS (QUESTRATION)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,966,339	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	14,832	30.01
31	INTERIM PAYMENTS	2,523,124	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	428,383	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 APPLICABLE BOXES:	[ ]	TITLE V	[XX]	HOSPITAL (14-1338)	[ ]	SNF	[ ]	PPS
	[XX]	TITLE XIX	[ ]	IPF	[ ]	NF	[ ]	TEFRA
			[ ]	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	288,082		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	288,082		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	288,082		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	265,919		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)	288,082		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	288,082		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)	288,082		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)	288,082		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)	288,082		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)	288,082		40
41	INTERIM PAYMENTS	49,535		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	238,547		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	1,237,880				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	7,271,013				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4,900,963				6
7	INVENTORY					7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	856,799				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,464,729				11
	FIXED ASSETS					
12	LAND	237,440				12
13	LAND IMPROVEMENTS	501,866				13
14	ACCUMULATED DEPRECIATION	-427,905				14
15	BUILDINGS	14,426,614				15
16	ACCUMULATED DEPRECIATION	-6,648,290				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	902,982				19
20	ACCUMULATED DEPRECIATION	-834,665				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	11,671,709				23
24	ACCUMULATED DEPRECIATION	-8,984,676				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)	10,845,075				30
	OTHER ASSETS					
31	INVESTMENTS	19,330,554				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS					34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	19,330,554				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	34,640,358				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	731,789				37
38	SALARIES, WAGES & FEES PAYABLE					38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,020,945				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,752,734				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)					50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	1,752,734				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	32,887,624				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)	32,887,624				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	34,640,358				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	32,736,387								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	151,237								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	32,887,624								3
4	ADDITIONS (CREDIT ADJUST-MENTS)									4
5	RESTRICTED FUND BALANCE CHANGE									5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	32,887,624								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13	CORRECTION									13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	32,887,624								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	1,386,067		1,386,067	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)	1,386,067		1,386,067	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)	1,386,067		1,386,067	17
18	ANCILLARY SERVICES	3,908,603		3,908,603	18
19	OUTPATIENT SERVICES		26,895,387	26,895,387	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)	5,294,670	26,895,387	32,190,057	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		19,457,489	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)		19,457,489	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	32,190,057	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	13,886,835	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	18,303,222	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	19,457,489	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,154,267	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	27,625	6
7	INCOME FROM INVESTMENTS	529,490	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	1,365	10
11	REBATES AND REFUNDS OF EXPENSES	49,281	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	56,701	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	85	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	336	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	359,541	23
24	OTHER (HFS HIT INCENTIVE PAYMENT)	184,350	24
24.01	OTHER (OTHER NON OP. REV.)	41,019	24.01
24.02	OTHER (REPLACEMENT TAX REVENUE FROM IL)	21,823	24.02
24.03	OTHER (HEALTHY HEARTS)	12,885	24.03
24.04	OTHER (DR. OFFICE BLDG REV)	160,342	24.04
24.05	OTHER (DIALYSIS BLDG REV)	57,744	24.05
24.06	OTHER (NON ALLOWABLE INCOME)	990	24.06
24.07	OTHER (PET SCANNER)	2,500	24.07
24.08	OTHER (SALE OF SCRAP AND WASTE)	3,434	24.08
24.09	OTHER (LSS REV)	4,050	24.09
24.10	OTHER (OTHER NON OP REV)	5,030	24.10
24.11	OTHER (MAINT. EMP.)	14,950	24.11
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,533,541	25
26	TOTAL (LINE 5 PLUS LINE 25)	379,274	26
27			27
27.01	OTHER EXPENSES (DR. OFFICE EXP)	178,099	27.01
27.02	OTHER EXPENSES (CCPC & SFP EXP)	3,193	27.02
27.03	OTHER EXPENSES (OTHER MISC EXP)	5,174	27.03
27.04	OTHER EXPENSES (LOSS G SEC)	39,693	27.04
27.05	OTHER EXPENSES (RENTAL BLDG)	1,878	27.05
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	228,037	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	151,237	29

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS COMPONENT NO: - WORKSHEET I-1

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		TOTAL COSTS 1	BASIS 2	STATISTICS 3	FTES PER 2080 HOURS 4	
1	REGISTERED NURSES		HOURS OF SERVICE			1
2	LICENSED PRACTICAL NURSES		HOURS OF SERVICE			2
3	NURSES AIDES		HOURS OF SERVICE			3
4	TECHNICIANS		HOURS OF SERVICE			4
5	SOCIAL WORKERS		HOURS OF SERVICE			5
6	DIETICIANS		HOURS OF SERVICE			6
7	PHYSICIANS		ACCUMULATED COST			7
8	NON-PATIENT CARE SALARY		ACCUMULATED COST			8
9	SUBTOTAL (SUM OF LINES 1-8)					9
10	EMPLOYEE BENEFITS		SALARY			10
11	CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11
12	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			12
13	MACHINES COSTS & REPAIRS		PERCENTAGE OF TIME			13
14	SUPPLIES		REQUISITIONS			14
15	DRUGS		REQUISITIONS			15
16	OTHER		ACCUMULATED COST			16
17	SUBTOTAL (SUM OF LINES 9-16)					17
18	CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			18
19	CAPITAL RELATED COSTS-MOVABLE EQUIPMENT		PERCENTAGE OF TIME			19
20	EMPLOYEE BENEFITS DEPARTMENT		SALARY			20
21	ADMINISTRATIVE AND GENERAL		ACCUMULATED COST			21
22	MAINT./REPAIRS-OPERATION-HOUSEKEEPING		SQUARE FEET			22
23	MEDICAL EDUCATION PROGRAM COSTS					23
24	CENTRAL SERVICES & SUPPLIES		REQUISITIONS			24
25	PHARMACY		REQUISITIONS			25
26	OTHER ALLOCATED COSTS		ACCUMULATED COST			26
27	SUBTOTAL (SUM OF LINES 17-26)					27
28	LABORATORY		CHARGES			28
29	RESPIRATORY THERAPY		CHARGES			29
30	CARDIAC REHAB		CHARGES			30
30.01	CHEMOTHERAPY		CHARGES			30.01
30.97	CARDIAC REHABILITATION		CHARGES			30.97
30.98	HYPERBARIC OXYGEN THERAPY		CHARGES			30.98
30.99	LITHOTRIPSY		CHARGES			30.99
31	TOTAL COSTS (SUM OF LINES 27-30)					31

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES COMPONENT NO: - WORKSHEET I-2

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		CAPITAL AND RELATED COSTS BUILDING 1	CAPITAL AND RELATED COSTS EQUIPMENT 2	DIRECT PATIENT CARE SALARY RNs 3	DIRECT PATIENT CARE SALARY OTHER 4	EMPLOYEE BENEFITS DEPARTMENT 5	DRUGS 6	
1	TOTAL RENAL DEPT COSTS							1
	MAINTENANCE							
2	HEMODIALYSIS							2
3	INTERMITTENT PERITONEAL							3
	TRAINING							
4	HEMODIALYSIS							4
5	INTERMITTENT PERITONEAL							5
6	CAPD							6
7	CCPD							7
	HOME							
8	HEMODIALYSIS							8
9	INTERMITTENT PERITONEAL							9
10	CAPD							10
11	CCPD							11
	OTHER BILLABLE SERVICES							
12	INPATIENT DIALYSIS							12
13	METHOD II HOME PATIENT							13
14	EPO (INCL IN RENAL DEPT)							14
15	ARANESP (INCL IN RENAL DEPT)							15
16	OTHER							16
17	TOTAL (SUM OF LINES 2-16)							17
18	MEDICAL EDUC PGM COSTS							18
19	TOTAL RENAL COSTS (LINES 17+18)							19

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODILITIES COMPONENT NO: - WORKSHEET I-2
(CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		MEDICAL SUPPLIES 7	ROUTINE ANCILLARY SERVICES 8	SUBTOTAL (SUM OF COLS.1-8) 9	OVERHEAD 10	TOTAL (COL.9 + COL.10) 11	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPATIENT DIALYSIS						12
13	METHOD II HOME PATIENT						13
14	EPO (INCL IN RENAL DEPT)						14
15	ARANESP (INCL IN RENAL DEPT)						15
16	OTHER						16
17	TOTAL (SUM OF LINES 2-16)						17
18	MEDICAL EDUC PGM COSTS						18
19	TOTAL RENAL COSTS (LINES 17+18)						19

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS — COMPONENT NO: - — WORKSHEET I-3

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		CAPITAL AND RELATED COSTS		DIRECT PATIENT CARE SALARY		EMPLOYEE BENEFITS	
		BUILDING (SQUARE FEET)	EQUIPMENT (% OF TIME)	RNs (HOURS)	OTHER (HOURS)	DEPARTMENT (SALARY)	
		1	2	3	4	5	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPT DIAL TRTMNTS						
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS						17
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)						18

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS — COMPONENT NO: - — WORKSHEET I-3 (CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		DRUGS (REQUIST.) 6	MEDICAL SUPPLIES (REQUIST.) 7	ROUTINE ANCILLARY SERVICES (CHARGES) 8	SUBTOTAL 9	OVERHEAD (ACCUM. COST) 10	
1	TOTAL RENAL DEPT COSTS						1
	MAINTENANCE						
2	HEMODIALYSIS						2
3	INTERMITTENT PERITONEAL						3
	TRAINING						
4	HEMODIALYSIS						4
5	INTERMITTENT PERITONEAL						5
6	CAPD						6
7	CCPD						7
	HOME						
8	HEMODIALYSIS						8
9	INTERMITTENT PERITONEAL						9
10	CAPD						10
11	CCPD						11
	OTHER BILLABLE SERVICES						
12	INPT DIAL TRTMNTS						
13	METHOD II HOME PATIENT						13
14	EPO						14
15	ARANESP						15
16	OTHER						16
17	TOTAL STATISTICAL BASIS						17
18	UNIT COST MULTIPLIER (LINE 1 ÷ LINE 17)						18

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS COMPONENT NO: - WORKSHEET I-4

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		NUMBER OF TOTAL TREATMENTS 1	TOTAL COST (FROM WKST I-2, COL. 11) 2	AVG COST OF PROGRAM TREATMENTS (COL. 2 ÷ COL. 1) 3	NUMBER OF PROGRAM TREATMENTS 4	NUMBER OF PROGRAM TREATMENTS 4.01	NUMBER OF PROGRAM TREATMENTS 4.02	TOTAL PROGRAM EXPENSES (SEE INSTR.) 5	
1	MAINTENANCE - HEMODIALYSIS								1
2	MAINTENANCE - PERITONEAL DIALYSIS								2
3	TRAINING - HEMODIALYSIS								3
4	TRAINING - PERITONEAL DIALYSIS								4
5	TRAINING - CAPD								5
6	TRAINING - CCPD								6
7	HOME PROGRAM - HEMODIALYSIS								7
8	HOME PROGRAM - PERITONEAL DIALYSIS								8
		PATIENT WEEKS			PATIENT WEEKS	PATIENT WEEKS	PATIENT WEEKS		
9	HOME PROGRAM - CAPD								9
10	HOME PROGRAM - CCPD								10
11	TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)								11
12	TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))								12

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS COMPONENT NO: - WORKSHEET I-4
(CONTINUED)

CHECK APPLICABLE BOX: [XX] RENAL DIALYSIS DEPARTMENT [ ] HOME PROGRAM DIALYSIS

		TOTAL PROGRAM PAYMENT 6	TOTAL PROGRAM PAYMENT 6.01	TOTAL PROGRAM PAYMENT 6.02	AVERAGE PAYMENT RATE (COL. 6 ÷ COL. 4) 7	AVERAGE PAYMENT RATE (COL. 6.01 ÷ COL. 4.01) 7.01	AVERAGE PAYMENT RATE (COL. 6.02 ÷ COL. 4.02) 7.02	
1	MAINTENANCE - HEMODIALYSIS							1
2	MAINTENANCE - PERITONEAL DIALYSIS							2
3	TRAINING - HEMODIALYSIS							3
4	TRAINING - PERITONEAL DIALYSIS							4
5	TRAINING - CAPD							5
6	TRAINING - CCPD							6
7	HOME PROGRAM - HEMODIALYSIS							7
8	HOME PROGRAM - PERITONEAL DIALYSIS							8
9	HOME PROGRAM - CAPD							9
10	HOME PROGRAM - CCPD							10
11	TOTALS (SUM OF LINES 1-8, COLS. 1 & 4) (SUM OF LINES 1-10, COLS. 2, 5 & 6)							11
12	TOTAL TREATMENTS (SUM OF LINES 1-8 PLUS (SUM OF LINES 9 AND 10 TIMES 3))							12

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B COMPONENT NO: - WORKSHEET I-5

	DESCRIPTION			
1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
		1	2	
2	TOTAL PAYMENT DUE (FROM I-4, COL. 6, LINE 11)(SEE INSTRUCTIONS)			2
2.01	TOTAL PAYMENT DUE (FROM I-4, COL. 6.01, LINE 11)(SEE INSTRUCTIONS)			2.01
2.02	TOTAL PAYMENT DUE (FROM I-4, COL. 6.02, LINE 11)(SEE INSTRUCTIONS)			2.02
2.03	TOTAL PAYMENT DUE (SEEINSTRUCTIONS)			2.03
2.04	OUTLIER PAYMENTS			2.04
3	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3
3.01	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.01
3.02	DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.02
3.03	TOTAL DEDUCTIBLES BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			3.03
4	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4
4.01	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.01
4.02	COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.02
4.03	TOTAL COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			4.03
5	BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE, NET OF BAD DEBT RECOVERIES			5
5.01	TRANSITION PERIOD 1 (75-25%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2011 BUT BEFORE 1/1/2012			5.01
5.02	TRANSITION PERIOD 2 (50-50%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2012 BUT BEFORE 1/1/2013			5.02
5.03	TRANSITION PERIOD 3 (25-75%) BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2013 BUT BEFORE 1/1/2014			5.03
5.04	100% PPS BAD DEBTS FOR DEDUCTIBLES AND COINSURANCE NET OF BAD DEBT RECOVERIES FOR SERVICES RENDERED ON OR AFTER 1/1/2014			5.04
5.05	TOTAL BAD DEBTS (SUM OF LINE 5 THROUGH LINE 5.04)			5.05
6	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)			6
7	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			7
8	NET DEDUCTIBLES AND COINSURANCE BILLED TO MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS			8
9	PROGRAM PAYMENT (SEE INSTRUCTIONS)			9
10	UNRECOVERED FROM MEDICARE (PART B) PATIENTS (SEE INSTRUCTIONS)			10
11	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) (TRANSFER TO WKST E, PART B, LINE 33)			11

PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE RATE PERCENTAGE

12	TOTAL ALLOWABLE EXPENSES (SEE INSTRUCTIONS)	12
13	TOTAL COMPOSITE COSTS (FROM WKST I-4, COL. 2, LINE 11)	13
14	FACILITY SPECIFIC COMPOSITE COST PERCENTAGE (LINE 13 DIVIDED BY LINE 12)	14

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

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING						5.03
5.04	ADMITTING						5.04
5.05	CREDIT AND COLLECTIONS						5.05
5.06	OTHER ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES						21
22	I&R SERVICES-OTHER PRGM COSTS						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD						62
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
71	MEDICAL SUPPLIES CHARGED TO PA						71
71.01	IMPLANTABLE SUPPLIES						71.01
71.02	PACEMAKERS						71.02
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76	CARDIAC REHAB						76
76.01	CHEMOTHERAPY						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT						92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CA						190
192	PHYSICIANS' PRIVATE OFFICES						192
193.01	CARDIAC REHAB						193.01
194	NON-ALLOWABLE COSTS						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND						202
	LINES 190-201)						
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204