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: 11-22-2013 TIME: 14:10_____
2. [ ] MANUALLY SUBMITTED COST REPORT
3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
4. [F] MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ST. FRANCIS HOSPITAL (14-1350) (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		593,572	789,844		617,575	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		46,366				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		639,938	789,844		617,575	200

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

PROVIDER CCN: 14-1350 ST. FRANCIS HOSPITAL | KPMG LLP COMPU-MAX MICRO SYSTEM | VERSION: 2013.11
PERIOD FROM 07/01/2012 TO 06/30/2013 | IN LIEU OF FORM CMS-2552-10 (08/2011) | 11/22/2013 14:10

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1215 FRANCISCAN DRIVE P.O.BOX: 1

2 CITY: LITCHFIELD STATE: IL ZIP CODE: 62056 COUNTY: MONTGOMERY 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	HOSPITAL	ST. FRANCIS HOSPITAL	14-1350	99914	1	12/01/2005	N	O	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	ST. FRANCIS HOSPITAL	14-Z350	99914		05/31/2007	N	O	O	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2012	TO: 06/30/2013							20
21	TYPE OF CONTROL	1								21

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS 2	OUT-OF STATE MEDICAID PAID DAYS 3	OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF THIS PROVIDER IS AN IPPS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25

				26
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		
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	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY	N	N	N	46

	CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.				
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

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

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

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

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

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

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

61.20

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

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

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

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

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

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

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

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

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

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

		V	XIX	
	TITLE V AND XIX INPATIENT SERVICES	1	2	
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97

		1	2	
	RURAL PROVIDERS			
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	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.	N	N	N	N	109

	MISCELLANEOUS COST REPORTING INFORMATION		
115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 81,364 PAID LOSSES: SELF INSURANCE: 389,754			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

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

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

ALL PROVIDERS

		1	2	
140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	148005	140

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

141	NAME: HOSPITAL SISTERS HEALTH SYSTEM CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES	CONTRACTOR'S NUMBER: 00131		141
142	STREET: 4736 LAVERNA ROAD P.O. BOX:			142
143	CITY: SPRINGFIELD STATE: IL	ZIP CODE: 62794		143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

MULTICAMPUS

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

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

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	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	DATE		
	PROVIDER ORGANIZATION AND OPERATION	1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			1

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

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

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

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

BED COMPLEMENT

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

		PART A		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	09/27/2013	Y	09/27/2013	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.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
	PROVIDER-BASED PHYSICIANS		
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35

		Y/N (1)	DATE (2)	
	HOME OFFICE COSTS			
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	Y		36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	Y		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.	Y		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N		40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: LESLIE	LAST NAME: MEWES	TITLE: DIRECTOR OF FINANCIA		41
42	EMPLOYER: ST FRANCIS HOSPITAL				42
43	PHONE NUMBER: 217-324-8368	E-MAIL ADDRESS: LESLIE.MEWES@HSHS.ORG			43

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

	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS TOTAL TITLE V	TITLE XVIII	TITLE XIX	ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)(SEE INSTRUCTIONS FOR COL. 2 FOR THE PORTION OF LDP ROOM AVAILABLE BEDS)	30	25	9,125	107,978.03		3,056	557	4,132	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						245		294	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	107,978.03		3,301	557	4,426	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						315	454	13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	107,978.03		3,301	872	4,880	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								594	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								44	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					757	488	1,331	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)			200.54			757	488	1,331	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)			200.54						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						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)							10
	OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING							16
	WAGE-RELATED COSTS							
17	WAGE-RELATED COSTS (CORE)							17
18	WAGE-RELATED COSTS (OTHER)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							43

PART III - HOSPITAL WAGE INDEX SUMMARY

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

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

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

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF | WORKSHEET S-7
STATISTICAL DATA

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

	GROUP (1)	SNF DAYS (2)	SWING BED SNF DAYS (3)	TOTAL (COLS. 2 + 3) (4)	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				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	69
70	PE1			70	70
71	PD2			71	71
72	PD1			72	72
73	PC2			73	73
74	PC1			74	74
75	PB2			75	75
76	PB1			76	76
77	PA2			77	77
78	PA1			78	78
199	AAA			199	199
200	TOTAL			200	200

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

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

		EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3	
202	STAFFING				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)	0.323722	1
	MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)		
2	NET REVENUE FROM MEDICAID	4,992,169	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	17,178,176	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)	5,560,953	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.	568,784	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	15,957	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)	568,784	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	1,852,537	158,086	2,010,623	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	599,707	51,176	650,883	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	41,619	5,731	47,350	22
23	COST OF CHARITY CARE	558,088	45,445	603,533	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)	2,448,377	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V	1,519,868	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)	928,509	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)	300,579	29
30	COST OF UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)	904,112	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)	1,472,896	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		510,107	510,107	-11,133	1
2	00200	CAP REL COSTS-MVBLE EQUIP		918,925	918,925		2
3	00300	OTHER CAP REL COSTS					3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	74,957	4,422,800	4,497,757	13,618	4
5.01	00570	ADMITTING	360,803	106,698	467,501		5.01
5.02	00590	PATIENT ACCOUNTING		336	336	274,110	5.02
5.03	00591	ADMIN & GENERAL	1,829,142	5,243,445	7,072,587	-834,295	5.03
6	00600	MAINTENANCE & REPAIRS	226,310	27,270	253,580		6
7	00700	OPERATION OF PLANT	67,373	767,660	835,033	-33,840	7
8	00800	LAUNDRY & LINEN SERVICE		2,665	2,665	121,424	8
9	00900	HOUSEKEEPING	278,821	220,439	499,260		9
10	01000	DIETARY	341,149	279,266	620,415	-256,561	10
11	01100	CAFETERIA				257,240	11
12	01200	MAINTENANCE OF PERSONNEL					12
13	01300	NURSING ADMINISTRATION	193,698	9,430	203,128		13
14	01400	CENTRAL SERVICES & SUPPLY					14
15	01500	PHARMACY	306,840	805,048	1,111,888	-561,720	15
16	01600	MEDICAL RECORDS & LIBRARY	328	51	379	354,290	16
17	01700	SOCIAL SERVICE					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	2,291,741	189,431	2,481,172	-1,192,186	30
43	04300	NURSERY				77,362	43
		ANCILLARY SERVICE COST CENTERS					
50	05000	OPERATING ROOM	837,787	746,963	1,584,750	-444,879	50
52	05200	DELIVERY ROOM & LABOR ROOM				500,217	52
53	05300	ANESTHESIOLOGY		864,258	864,258	-12,466	53
54	05400	RADIOLOGY-DIAGNOSTIC	879,707	394,281	1,273,988	-15,831	54
57	05700	CT SCAN	82,697	174,222	256,919	2,842	57
58	05800	MRI	69,205	164,532	233,737	1,857	58
60	06000	LABORATORY	602,316	1,045,907	1,648,223	76,464	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	06500	RESPIRATORY THERAPY	277,895	116,657	394,552	1,277	65
66	06600	PHYSICAL THERAPY	201,964	76,260	278,224	20,743	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		68,614	68,614	326,012	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				159,250	72
73	07300	DRUGS CHARGED TO PATIENTS				1,169,026	73
74	07400	RENAL DIALYSIS					74
76.97	07697	CARDIAC REHABILITATION	134,030	13,583	147,613		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99	07699	LITHOTRIPSY					76.99
		OUTPATIENT SERVICE COST CENTERS					
91	09100	EMERGENCY	838,895	1,791,848	2,630,743	-34,591	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)	9,895,658	18,960,696	28,856,354	-41,770	118
		NONREIMBURSABLE COST CENTERS					
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		37,783	37,783		190
192	19200	PHYSICIANS' PRIVATE OFFICES	166,793	660,402	827,195	41,770	192
194	07950	OTHER NONALLOWABLE	63,378	83,952	147,330		194
200		TOTAL (SUM OF LINES 118-199)	10,125,829	19,742,833	29,868,662		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	498,974		498,974	1
2	00200	CAP REL COSTS-MVBLE EQUIP	918,925		918,925	2
3	00300	OTHER CAP REL COSTS				3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	4,511,375	-719,303	3,792,072	4
5.01	00570	ADMITTING	467,501		467,501	5.01
5.02	00590	PATIENT ACCOUNTING	274,446		274,446	5.02
5.03	00591	ADMIN & GENERAL	6,238,292	-535,488	5,702,804	5.03
6	00600	MAINTENANCE & REPAIRS	253,580		253,580	6
7	00700	OPERATION OF PLANT	801,193		801,193	7
8	00800	LAUNDRY & LINEN SERVICE	124,089		124,089	8
9	00900	HOUSEKEEPING	499,260		499,260	9
10	01000	DIETARY	363,854		363,854	10
11	01100	CAFETERIA	257,240	-442	256,798	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	203,128	-30	203,098	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	550,168		550,168	15
16	01600	MEDICAL RECORDS & LIBRARY	354,669		354,669	16
17	01700	SOCIAL SERVICE				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	1,288,986		1,288,986	30
43	04300	NURSERY	77,362		77,362	43
		ANCILLARY SERVICE COST CENTERS				
50	05000	OPERATING ROOM	1,139,871		1,139,871	50
52	05200	DELIVERY ROOM & LABOR ROOM	500,217		500,217	52
53	05300	ANESTHESIOLOGY	851,792	-744,432	107,360	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,258,157	-7,470	1,250,687	54
57	05700	CT SCAN	259,761		259,761	57
58	05800	MRI	235,594		235,594	58
60	06000	LABORATORY	1,724,687	-30,000	1,694,687	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	395,829	-35,208	360,621	65
66	06600	PHYSICAL THERAPY	298,967	-420	298,547	66
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	394,626		394,626	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS	159,250		159,250	72
73	07300	DRUGS CHARGED TO PATIENTS	1,169,026		1,169,026	73
74	07400	RENAL DIALYSIS				74
76.97	07697	CARDIAC REHABILITATION	147,613		147,613	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
		OUTPATIENT SERVICE COST CENTERS				
91	09100	EMERGENCY	2,596,152	-1,715,451	880,701	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)	28,814,584	-3,788,244	25,026,340	118
		NONREIMBURSABLE COST CENTERS				
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,783		37,783	190
192	19200	PHYSICIANS' PRIVATE OFFICES	868,965	-562,596	306,369	192
194	07950	OTHER NONALLOWABLE	147,330		147,330	194
200		TOTAL (SUM OF LINES 118-199)	29,868,662	-4,350,840	25,517,822	200

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY L&D AND NURSERY COST	A	NURSERY	43	70,186	7,300	1
2			DELIVERY ROOM & LABOR ROOM	52	455,621	47,389	2
500	TOTAL RECLASSIFICATIONS				525,807	54,689	500
	CODE LETTER - A						
1	RECLASSIFY DRUG COSTS	B	DRUGS CHARGED TO PATIENTS	73		689,657	1
500	TOTAL RECLASSIFICATIONS					689,657	500
	CODE LETTER - B						
1	RECLASSIFY CAFETERIA COSTS	C	CAFETERIA	11	235,476	21,764	1
500	TOTAL RECLASSIFICATIONS				235,476	21,764	500
	CODE LETTER - C						
1	RECLASSIFY LAUNDRY COSTS	D	LAUNDRY & LINEN SERVICE	8		121,424	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
500	TOTAL RECLASSIFICATIONS					121,424	500
	CODE LETTER - D						
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	MEDICAL SUPPLIES CHARGED TO P	71		326,012	1
2			IMPL. DEV. CHARGED TO PATIENT	72		159,250	2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					485,262	500
	CODE LETTER - E						
1	DRUG ADMINISTRATION COSTS	F	LABORATORY	60	67,407	3,683	1
2			DRUGS CHARGED TO PATIENTS	73	460,961	18,981	2
500	TOTAL RECLASSIFICATIONS				528,368	22,664	500
	CODE LETTER - F						
1	RECLASSIFY DEPREC COSTS FOR MOB	G	PHYSICIANS' PRIVATE OFFICES	192		45,239	1
500	TOTAL RECLASSIFICATIONS					45,239	500
	CODE LETTER - G						
1	RECLASSIFY SHARED SERVICE COSTS	H	EMPLOYEE BENEFITS DEPARTMENT	4		13,618	1
2			PATIENT ACCOUNTING	5.02		1,357	2
3			DIETARY	10		679	3
4			PHARMACY	15		127,937	4
5			ADULTS & PEDIATRICS	30		1,487	5
6			RADIOLOGY-DIAGNOSTIC	54		6,483	6
7			LABORATORY	60		8,545	7
8			RESPIRATORY THERAPY	65		25,667	8
9			PHYSICAL THERAPY	66		21,266	9
500	TOTAL RECLASSIFICATIONS					207,039	500
	CODE LETTER - H						
1	RECLASSIFY BUILDING INSURANCE COSTS	I	CAP REL COSTS-BLDG & FIXT	1		34,106	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					34,106	500
	CODE LETTER - I						

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	RECLASSIFY RADIOLOGY MGR COSTS	J	CT SCAN	57	6,479	1
2			MRI	58	5,436	2
500	TOTAL RECLASSIFICATIONS				11,915	500
	CODE LETTER - J					
1	MEDICAL RECORDS	K	MEDICAL RECORDS & LIBRARY	16	146,382	207,908 1
500	TOTAL RECLASSIFICATIONS				146,382	207,908 500
	CODE LETTER - K					
1	PATIENT ACCOUNTING	L	PATIENT ACCOUNTING	5.02	238,169	34,584 1
500	TOTAL RECLASSIFICATIONS				238,169	34,584 500
	CODE LETTER - L					
	GRAND TOTAL (INCREASES)				1,686,117	1,924,336

RECLASSIFICATIONS WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.
		1	6	7	8	9	10
1	RECLASSIFY L&D AND NURSERY COST	A	ADULTS & PEDIATRICS	30	525,807	54,689	1
2							2
500	TOTAL RECLASSIFICATIONS				525,807	54,689	500
	CODE LETTER - A						
1	RECLASSIFY DRUG COSTS	B	PHARMACY	15		689,657	1
500	TOTAL RECLASSIFICATIONS					689,657	500
	CODE LETTER - B						
1	RECLASSIFY CAFETERIA COSTS	C	DIETARY	10	235,476	21,764	1
500	TOTAL RECLASSIFICATIONS				235,476	21,764	500
	CODE LETTER - C						
1	RECLASSIFY LAUNDRY COSTS	D	ADULTS & PEDIATRICS	30		63,513	1
2			OPERATING ROOM	50		15,400	2
3			RADIOLOGY-DIAGNOSTIC	54		10,399	3
4			CT SCAN	57		3,637	4
5			MRI	58		1,612	5
6			LABORATORY	60		3,171	6
7			RESPIRATORY THERAPY	65		1,868	7
8			PHYSICAL THERAPY	66		183	8
9			EMERGENCY	91		18,225	9
10			PHYSICIANS' PRIVATE OFFICES	192		3,416	10
500	TOTAL RECLASSIFICATIONS					121,424	500
	CODE LETTER - D						
1	RECLASSIFY MEDICAL SUPPLY COSTS	E	NURSERY	43		124	1
2			OPERATING ROOM	50		429,479	2
3			DELIVERY ROOM & LABOR ROOM	52		2,793	3
4			ANESTHESIOLOGY	53		12,466	4
5			MRI	58		1,967	5
6			RESPIRATORY THERAPY	65		22,522	6
7			PHYSICAL THERAPY	66		340	7
8			DRUGS CHARGED TO PATIENTS	73		573	8
9			EMERGENCY	91		14,998	9
500	TOTAL RECLASSIFICATIONS					485,262	500
	CODE LETTER - E						
1	DRUG ADMINISTRATION COSTS	F	ADULTS & PEDIATRICS	30	527,926	21,738	1
2			EMERGENCY	91	442	926	2
500	TOTAL RECLASSIFICATIONS				528,368	22,664	500
	CODE LETTER - F						
1	RECLASSIFY DEPREC COSTS FOR MOB	G	CAP REL COSTS-BLDG & FIXT	1		45,239	12 1
500	TOTAL RECLASSIFICATIONS					45,239	500
	CODE LETTER - G						
1	RECLASSIFY SHARED SERVICE COSTS	H	ADMIN & GENERAL	5.03		207,039	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
500	TOTAL RECLASSIFICATIONS					207,039	500
	CODE LETTER - H						
1	RECLASSIFY BUILDING INSURANCE COSTS	I	ADMIN & GENERAL	5.03		213	12 1
2			OPERATION OF PLANT	7		33,840	2
3			PHYSICIANS' PRIVATE OFFICES	192		53	3
500	TOTAL RECLASSIFICATIONS					34,106	500
	CODE LETTER - I						

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	RECLASSIFY RADIOLOGY MGR COSTS	J	RADIOLOGY-DIAGNOSTIC	54		11,915	1
2							2
500	TOTAL RECLASSIFICATIONS					11,915	500
	CODE LETTER - J						
1	MEDICAL RECORDS	K	ADMIN & GENERAL	5.03	146,382	207,908	1
500	TOTAL RECLASSIFICATIONS				146,382	207,908	500
	CODE LETTER - K						
1	PATIENT ACCOUNTING	L	ADMIN & GENERAL	5.03	238,169	34,584	1
500	TOTAL RECLASSIFICATIONS				238,169	34,584	500
	CODE LETTER - L						
	GRAND TOTAL (DECREASES)				1,674,202	1,936,251	

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	99,383					99,383		1
2	LAND IMPROVEMENTS	1,257,840	508,466		508,466		1,766,306		2
3	BUILDINGS AND FIXTURES	21,775,494	7,799,381		7,799,381		29,574,875		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	16,643,010	1,292,624		1,292,624		17,935,634		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (SUM OF LINES 1-7)	39,775,727	9,600,471		9,600,471		49,376,198		8
9	RECONCILING ITEMS								9
10	TOTAL (LINE 7 MINUS LINE 9)	39,775,727	9,600,471		9,600,471		49,376,198		10

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

	DESCRIPTION	SUMMARY OF CAPITAL: DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(1) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	510,107						510,107	1
2	CAP REL COSTS-MVBLE EQUIP	918,925						918,925	2
3	TOTAL (SUM OF LINES 1-2)	1,429,032						1,429,032	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									1
2	CAP REL COSTS-MVBLE EQUIP									2
3	TOTAL (SUM OF LINES 1-2)									3

	DESCRIPTION	SUMMARY OF CAPITAL: DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (SEE INSTR.) (12)	TAXES (SEE INSTR.) (13)	OTHER CAPITAL-RELATED COSTS (SEE INSTR.) (14)	TOTAL(2) (SUM OF COLS. 9-14) (15)	
1	CAP REL COSTS-BLDG & FIXT	510,107			-11,133			498,974	1
2	CAP REL COSTS-MVBLE EQUIP	918,925						918,925	2
3	TOTAL	1,429,032			-11,133			1,417,899	3

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5	REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)	B	-287	CAFETERIA	11	5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9	PARKING LOT (CHAPTER 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,796,347			10
11	SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	507,646			12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-155	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	MISC	B	-141,435	ADMIN & GENERAL	5.03	33
33.01	LAMAZE CLASS	B	-30	NURSING ADMINISTRATION	13	33.01
33.03	EMPL & COMM EDUCATION	B	-420	PHYSICAL THERAPY	66	33.03
33.04	XRAY REBATES	B	-7,470	RADIOLOGY-DIAGNOSTIC	54	33.04
34						34
35						35
36	PHYSICIAN RECRUITMENT	A	-274,008	ADMIN & GENERAL	5.03	36
37	MEDICAID TAX ASSESSTMENT	A	-651,646	ADMIN & GENERAL	5.03	37
38	SELF-INS TO HOSP/EMPLOYEE CLAIMS	A	-674,453	EMPLOYEE BENEFITS DEPARTMENT	4	38
39						39
40						40
41	CHARITY EXPENSE	A	-6,000	ADMIN & GENERAL	5.03	41
42	LOBBYING AND ADVERTISING COSTS	A	-14,895	ADMIN & GENERAL	5.03	42
43	PURCHASED SERVICES - HSHS MED GROU	A	-291,340	PHYSICIANS' PRIVATE OFFICES	192	43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,350,840			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	4	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE PREMIUMS	2,057,649	2,102,499	-44,850		1
2	4	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY SERV SJS	4,000	4,000			2
3	5.03	ADMIN & GENERAL	CONTRACT SERV HSHS	2,396,091	1,843,595	552,496		3
3.01	5.03	ADMIN & GENERAL	RELATED PARTY SERV HSHS	324,986	324,986			4.01
3.02	5.03	ADMIN & GENERAL	RELATED PARTY SERV SJS	65,358	65,358			4.02
3.03	5.03	ADMIN & GENERAL	RELATED PARTY SERV SMS	17,935	17,935			4.03
3.04	8	LAUNDRY & LINEN SERVICE	RELATED PARTY SERV SJS	124,087	124,087			4.04
3.05	10	DIETARY	RELATED PARTY SERV SEHB	24	24			4.05
3.06	10	DIETARY	RELATED PARTY SERV SJS	24	24			4.06
3.07	60	LABORATORY	RELATED PARTY SERV SJS	136,351	136,351			4.07
3.08	60	LABORATORY	RELATED PARTY SERV SMD	7,048	7,048			4.08
3.09	65	RESPIRATORY THERAPY	RELATED PARTY SERV SJS	200	200			4.09
3.10	66	PHYSICAL THERAPY	RELATED PARTY SERV SJS	45,024	45,024			4.10
3.11	71	MEDICAL SUPPLIES CHARGED TO PAT	RELATED PARTY SERV SJS	1,379	1,379			4.11
3.12	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY SERV SJB	440	440			4.12
3.13	73	DRUGS CHARGED TO PATIENTS	RELATED PARTY SERV SJS	10,855	10,855			4.13
4								4
5		TOTALS (SUM OF LINES 1-4) TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.		5,191,451	4,683,805	507,646		5

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	B		HOSPITAL SISTERS HEALTH SYSTEM	CORPORATE OFFICE		6
7	G		ST. MARY'S HOSPITAL	HOSPITAL		7
8	G		ST. JOHN'S HOSPITAL	HOSPITAL		8
9	G		ST. JOSEPH'S HOSPITAL-BREESE	HOSPITAL		9
10	G		ST. ELIZABETH'S HOSPITAL	HOSPITAL		10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA-TION INCL FRINGES	PROFES-SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD-JUSTED RCE LIMIT	5 PERCENT OF UNAD-JUSTED RCE LIMIT	
	1	2		3	4	5	6	7	8	9	
1	53	ANESTHESIOLOGY	VARIOUS	744,432	744,432						1
2	60	LABORATORY	VARIOUS	30,000	30,000						2
3	65	RESPIRATORY THERAPY	VARIOUS	35,208	35,208						3
4	91	EMERGENCY	VARIOUS	1,715,451	1,715,451						4
5	192	PHYSICIANS' PRIVATE OFFI	VARIOUS	271,256	271,256						5
200		TOTAL		2,796,347	2,796,347						200

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT	
	10	11		12	13	14	15	16	17	18	
1	53	ANESTHESIOLOGY	VARIOUS							744,432	1
2	60	LABORATORY	VARIOUS							30,000	2
3	65	RESPIRATORY THERAPY	VARIOUS							35,208	3
4	91	EMERGENCY	VARIOUS							1,715,451	4
5	192	PHYSICIANS' PRIVATE OFFI	VARIOUS							271,256	5
200		TOTAL								2,796,347	200

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS DEPARTMENT 4	NON-PATIENT TELEPHONES 5.01	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	498,974	498,974				1
2	CAP REL COSTS-MVBLE EQUIP	918,925		918,925			2
4	EMPLOYEE BENEFITS DEPARTMENT	3,792,072	10,461	4,286	3,806,819		4
5.01	ADMITTING	467,501	4,129	4,686	136,494	612,810	5.01
5.02	PATIENT ACCOUNTING	274,446	23,111	1,211	90,101		5.02
5.03	ADMIN & GENERAL	5,702,804	87,688	175,074	546,495		5.03
6	MAINTENANCE & REPAIRS	253,580			85,615		6
7	OPERATION OF PLANT	801,193	100,852	9,793	25,488		7
8	LAUNDRY & LINEN SERVICE	124,089	4,110				8
9	HOUSEKEEPING	499,260	5,186	261	105,480		9
10	DIETARY	363,854	28,025	16,220	39,977		10
11	CAFETERIA	256,798	7,961		89,082		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	203,098	2,454	23,126	73,277		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	550,168	4,131	9,984	116,080		15
16	MEDICAL RECORDS & LIBRARY	354,669	7,392	7,278	55,501		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,288,986	64,315	45,689	468,347	52,663	30
43	NURSERY	77,362	2,373		26,552		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,139,871	25,517	181,587	316,941	56,032	50
52	DELIVERY ROOM & LABOR ROOM	500,217	6,990		172,365		52
53	ANESTHESIOLOGY	107,360	766	41,976		28,067	53
54	RADIOLOGY-DIAGNOSTIC	1,250,687	19,425	164,212	332,799	85,331	54
57	CT SCAN	259,761	1,448	131,900	33,736	95,010	57
58	MRI	235,594			28,237	39,113	58
60	LABORATORY	1,694,687	14,080	8,212	253,361	86,047	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	360,621	7,405	20,867	105,130	32,106	65
66	PHYSICAL THERAPY	298,547	13,373	5,711	76,404	12,106	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	394,626	7,883			6,392	71
72	IMPL. DEV. CHARGED TO PATIENTS	159,250					72
73	DRUGS CHARGED TO PATIENTS	1,169,026			174,385	35,019	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	147,613	5,016	18,084	50,704	2,241	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	880,701	16,685	42,863	317,193	82,683	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)	25,026,340	470,776	913,020	3,719,744	612,810	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,783	1,052	368			190
192	PHYSICIANS' PRIVATE OFFICES	306,369	27,146	3,705	63,099		192
194	OTHER NONALLOWABLE	147,330		1,832	23,976		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	25,517,822	498,974	918,925	3,806,819	612,810	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	DATA PRO-CESSING 5.02	SUBTOTAL (COLS.0-4) 4A	PURCHASING RECEIVING AND STORES 5.03	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING	388,869					5.02
5.03	ADMIN & GENERAL		6,512,061	6,512,061			5.03
6	MAINTENANCE & REPAIRS		339,195	116,220	455,415		6
7	OPERATION OF PLANT		937,326	321,162	122,941	1,381,429	7
8	LAUNDRY & LINEN SERVICE		128,199	43,926	5,010	20,817	8
9	HOUSEKEEPING		610,187	209,072	6,322	26,267	9
10	DIETARY		448,076	153,527	34,164	141,950	10
11	CAFETERIA		353,841	121,239	9,705	40,323	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		301,955	103,461	2,992	12,430	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		680,363	233,117	5,036	20,926	15
16	MEDICAL RECORDS & LIBRARY		424,840	145,565	9,011	37,441	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	33,414	1,953,414	669,310	78,403	325,768	30
43	NURSERY		106,287	36,418	2,893	12,020	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	35,552	1,755,500	601,497	31,106	129,246	50
52	DELIVERY ROOM & LABOR ROOM		679,572	232,846	8,521	35,405	52
53	ANESTHESIOLOGY	17,808	195,977	67,149	934	3,879	53
54	RADIOLOGY-DIAGNOSTIC	54,141	1,906,595	653,268	23,680	98,390	54
57	CT SCAN	60,331	582,186	199,478	1,765	7,335	57
58	MRI	24,817	327,761	112,303			58
60	LABORATORY	54,596	2,110,983	723,300	17,164	71,316	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	20,371	546,500	187,251	9,027	37,509	65
66	PHYSICAL THERAPY	7,681	413,822	141,790	16,303	67,738	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,056	412,957	141,494	9,609	39,927	71
72	IMPL. DEV. CHARGED TO PATIENTS		159,250	54,565			72
73	DRUGS CHARGED TO PATIENTS	22,219	1,400,649	479,913			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	1,422	225,080	77,121	6,115	25,407	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	52,461	1,392,586	477,150	20,340	84,511	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)	388,869	24,905,162	6,302,142	421,041	1,238,605	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		39,203	13,432	1,282	5,327	190
192	PHYSICIANS' PRIVATE OFFICES		400,319	137,164	33,092	137,497	192
194	OTHER NONALLOWABLE		173,138	59,323			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	388,869	25,517,822	6,512,061	455,415	1,381,429	202

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		8	9	10	11	13	
	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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	197,952					8
9	HOUSEKEEPING		851,848				9
10	DIETARY			777,717			10
11	CAFETERIA				525,108		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		5,740		2,860	429,438	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		1,065		164,847		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	81,843	176,008	777,717	105,817	217,332	30
43	NURSERY	2,897	7,962		3,117	6,403	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	25,106	108,651		42,470	87,227	50
52	DELIVERY ROOM & LABOR ROOM	18,803	51,803		20,162	41,411	52
53	ANESTHESIOLOGY		7,592				53
54	RADIOLOGY-DIAGNOSTIC	16,955	59,071		39,152		54
57	CT SCAN	5,929	5,370		5,548		57
58	MRI	2,628			4,633		58
60	LABORATORY	5,170	44,951		36,063		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	3,045	21,388		16,845		65
66	PHYSICAL THERAPY	298	8,287		9,895		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		6,666				71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS		5,277		10,667		73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		15,740		6,006		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	29,711	114,114		37,522	77,065	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)	192,385	639,685	777,717	505,604	429,438	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,426				190
192	PHYSICIANS' PRIVATE OFFICES	5,567	208,737		16,387		192
194	OTHER NONALLOWABLE				3,117		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	197,952	851,848	777,717	525,108	429,438	202

COST ALLOCATION - GENERAL SERVICE COSTS — WORKSHEET B PART I

	COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
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	939,442					15
16	MEDICAL RECORDS & LIBRARY		782,769				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		67,267	4,452,879		4,452,879	30
43	NURSERY			177,997		177,997	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		71,571	2,852,374		2,852,374	50
52	DELIVERY ROOM & LABOR ROOM			1,088,523		1,088,523	52
53	ANESTHESIOLOGY		35,850	311,381		311,381	53
54	RADIOLOGY-DIAGNOSTIC		108,995	2,906,106		2,906,106	54
57	CT SCAN		121,377	928,988		928,988	57
58	MRI		49,959	497,284		497,284	58
60	LABORATORY		109,909	3,118,856		3,118,856	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		41,009	862,574		862,574	65
66	PHYSICAL THERAPY		15,463	673,596		673,596	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		8,164	618,817		618,817	71
72	IMPL. DEV. CHARGED TO PATIENTS			213,815		213,815	72
73	DRUGS CHARGED TO PATIENTS	939,442	44,730	2,880,678		2,880,678	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		2,863	358,332		358,332	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		105,612	2,338,611		2,338,611	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)	939,442	782,769	24,280,811		24,280,811	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			62,670		62,670	190
192	PHYSICIANS' PRIVATE OFFICES			938,763		938,763	192
194	OTHER NONALLOWABLE			235,578		235,578	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	939,442	782,769	25,517,822		25,517,822	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT		10,461	4,286	14,747	14,747	4
5.01	ADMITTING		4,129	4,686	8,815	529	5.01
5.02	PATIENT ACCOUNTING	447,612	23,111	1,211	471,934	349	5.02
5.03	ADMIN & GENERAL	24,061	87,688	175,074	286,823	2,121	5.03
6	MAINTENANCE & REPAIRS					332	6
7	OPERATION OF PLANT	1,310	100,852	9,793	111,955	99	7
8	LAUNDRY & LINEN SERVICE		4,110		4,110		8
9	HOUSEKEEPING	600	5,186	261	6,047	408	9
10	DIETARY		28,025	16,220	44,245	155	10
11	CAFETERIA		7,961		7,961	345	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		2,454	23,126	25,580	284	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		4,131	9,984	14,115	450	15
16	MEDICAL RECORDS & LIBRARY		7,392	7,278	14,670	215	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		64,315	45,689	110,004	1,814	30
43	NURSERY		2,373		2,373	103	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	965	25,517	181,587	208,069	1,227	50
52	DELIVERY ROOM & LABOR ROOM		6,990		6,990	667	52
53	ANESTHESIOLOGY	3,040	766	41,976	45,782		53
54	RADIOLOGY-DIAGNOSTIC		19,425	164,212	183,637	1,289	54
57	CT SCAN		1,448	131,900	133,348	131	57
58	MRI					109	58
60	LABORATORY	12,648	14,080	8,212	34,940	981	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	10,954	7,405	20,867	39,226	407	65
66	PHYSICAL THERAPY		13,373	5,711	19,084	296	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,590	7,883		10,473		71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	92,932			92,932	675	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		5,016	18,084	23,100	196	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		16,685	42,863	59,548	1,228	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)	596,712	470,776	913,020	1,980,508	14,410	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93	1,052	368	1,513		190
192	PHYSICIANS' PRIVATE OFFICES		27,146	3,705	30,851	244	192
194	OTHER NONALLOWABLE	6,600		1,832	8,432	93	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	603,405	498,974	918,925	2,021,304	14,747	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	NON-PATIENT TELEPHONES 5.01	DATA PRO-CESSING 5.02	PURCHASING RECEIVING AND STORES 5.03	MAIN-TENANCE & REPAIRS 6	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMITTING	9,344					5.01
5.02	PATIENT ACCOUNTING		472,283				5.02
5.03	ADMIN & GENERAL			288,944			5.03
6	MAINTENANCE & REPAIRS			5,157	5,489		6
7	OPERATION OF PLANT			14,250	1,482	127,786	7
8	LAUNDRY & LINEN SERVICE			1,949	60	1,926	8
9	HOUSEKEEPING			9,277	76	2,430	9
10	DIETARY			6,812	412	13,131	10
11	CAFETERIA			5,379	117	3,730	11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION			4,591	36	1,150	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY			10,344	61	1,936	15
16	MEDICAL RECORDS & LIBRARY			6,459	109	3,463	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	802	40,583	29,698	945	30,132	30
43	NURSERY			1,616	35	1,112	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	853	43,180	26,689	375	11,956	50
52	DELIVERY ROOM & LABOR ROOM			10,332	103	3,275	52
53	ANESTHESIOLOGY	427	21,629	2,979	11	359	53
54	RADIOLOGY-DIAGNOSTIC	1,300	65,758	28,986	285	9,101	54
57	CT SCAN	1,460	73,255	8,851	21	679	57
58	MRI	596	30,141	4,983			58
60	LABORATORY	1,310	66,310	32,093	207	6,597	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	489	24,742	8,308	109	3,470	65
66	PHYSICAL THERAPY	184	9,329	6,291	196	6,266	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	97	4,926	6,278	116	3,693	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,421			72
73	DRUGS CHARGED TO PATIENTS	533	26,986	21,294			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	34	1,727	3,422	74	2,350	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,259	63,717	21,171	245	7,818	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)	9,344	472,283	279,630	5,075	114,574	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			596	15	493	190
192	PHYSICIANS' PRIVATE OFFICES			6,086	399	12,719	192
194	OTHER NONALLOWABLE			2,632			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	9,344	472,283	288,944	5,489	127,786	202

ALLOCATION OF CAPITAL-RELATED COSTS WORKSHEET B PART II

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		8	9	10	11	13	
	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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE	8,045					8
9	HOUSEKEEPING		18,238				9
10	DIETARY			64,755			10
11	CAFETERIA				17,532		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		123		95	31,859	13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY		23		5,505		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	3,327	3,768	64,755	3,533	16,124	30
43	NURSERY	118	170		104	475	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,020	2,326		1,418	6,471	50
52	DELIVERY ROOM & LABOR ROOM	764	1,109		673	3,072	52
53	ANESTHESIOLOGY		163				53
54	RADIOLOGY-DIAGNOSTIC	689	1,265		1,307		54
57	CT SCAN	241	115		185		57
58	MRI	107			155		58
60	LABORATORY	210	962		1,204		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	124	458		562		65
66	PHYSICAL THERAPY	12	177		330		66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		143				71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS		113		356		73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		337		201		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	1,207	2,443		1,253	5,717	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)	7,819	13,695	64,755	16,881	31,859	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		73				190
192	PHYSICIANS' PRIVATE OFFICES	226	4,470		547		192
194	OTHER NONALLOWABLE				104		194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	8,045	18,238	64,755	17,532	31,859	202

ALLOCATION OF CAPITAL-RELATED COSTS — WORKSHEET B PART II

	COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
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	26,906					15
16	MEDICAL RECORDS & LIBRARY		30,444				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		2,615	308,100		308,100	30
43	NURSERY			6,106		6,106	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		2,783	306,367		306,367	50
52	DELIVERY ROOM & LABOR ROOM			26,985		26,985	52
53	ANESTHESIOLOGY		1,394	72,744		72,744	53
54	RADIOLOGY-DIAGNOSTIC		4,238	297,855		297,855	54
57	CT SCAN		4,731	223,017		223,017	57
58	MRI		1,942	38,033		38,033	58
60	LABORATORY		4,273	149,087		149,087	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		1,594	79,489		79,489	65
66	PHYSICAL THERAPY		601	42,766		42,766	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		317	26,043		26,043	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,421		2,421	72
73	DRUGS CHARGED TO PATIENTS	26,906	1,739	171,534		171,534	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		111	31,552		31,552	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		4,106	169,712		169,712	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)	26,906	30,444	1,951,811		1,951,811	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			2,690		2,690	190
192	PHYSICIANS' PRIVATE OFFICES			55,542		55,542	192
194	OTHER NONALLOWABLE			11,261		11,261	194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINES 118-201)	26,906	30,444	2,021,304		2,021,304	202

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES 4	NON-PATIENT TELEPHONES GROSS SALARIES 5.01	DATA PRO-CESSING GROSS SALARIES 5.02	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT	185,026					1
2	CAP REL COSTS-MVBLE EQUIP		918,924				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,879	4,286	10,062,787			4
5.01	ADMITTING	1,531	4,686	360,803	81,159,803		5.01
5.02	PATIENT ACCOUNTING	8,570	1,211	238,169		81,159,803	5.02
5.03	ADMIN & GENERAL	32,516	175,074	1,444,591			5.03
6	MAINTENANCE & REPAIRS			226,310			6
7	OPERATION OF PLANT	37,397	9,793	67,373			7
8	LAUNDRY & LINEN SERVICE	1,524					8
9	HOUSEKEEPING	1,923	261	278,821			9
10	DIETARY	10,392	16,220	105,673			10
11	CAFETERIA	2,952		235,476			11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	910	23,126	193,698			13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	1,532	9,984	306,840			15
16	MEDICAL RECORDS & LIBRARY	2,741	7,278	146,710			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	23,849	45,689	1,238,008	6,974,272	6,974,272	30
43	NURSERY	880		70,186			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	9,462	181,586	837,787	7,420,479	7,420,479	50
52	DELIVERY ROOM & LABOR ROOM	2,592		455,621			52
53	ANESTHESIOLOGY	284	41,976		3,716,983	3,716,983	53
54	RADIOLOGY-DIAGNOSTIC	7,203	164,212	879,707	11,300,650	11,300,650	54
57	CT SCAN	537	131,900	89,176	12,586,231	12,586,231	57
58	MRI			74,641	5,179,820	5,179,820	58
60	LABORATORY	5,221	8,212	669,723	11,395,470	11,395,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,746	20,867	277,895	4,251,851	4,251,851	65
66	PHYSICAL THERAPY	4,959	5,711	201,964	1,603,250	1,603,250	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,923			846,489	846,489	71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS			460,961	4,637,630	4,637,630	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	1,860	18,084	134,030	296,789	296,789	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	6,187	42,863	838,453	10,949,889	10,949,889	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)	174,570	913,019	9,832,616	81,159,803	81,159,803	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	390	368				190
192	PHYSICIANS' PRIVATE OFFICES	10,066	3,705	166,793			192
194	OTHER NONALLOWABLE		1,832	63,378			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	498,974	918,925	3,806,819	612,810	388,869	202
203	UNIT COST MULT-WS B PT I	2.696778	1.000001	0.378307	0.007551	0.004791	203
204	COST TO BE ALLOC PER B PT II			14,747	9,344	472,283	204
205	UNIT COST MULT-WS B PT II			0.001465	0.000115	0.005819	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	RECON-CILIATION	PURCHASING RECEIVING AND STORES ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		5A.03	5.03	6	7	8	
	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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL	-6,512,061	19,005,761				5.03
6	MAINTENANCE & REPAIRS		339,195	138,530			6
7	OPERATION OF PLANT		937,326	37,397	101,133		7
8	LAUNDRY & LINEN SERVICE		128,199	1,524	1,524	121,424	8
9	HOUSEKEEPING		610,187	1,923	1,923		9
10	DIETARY		448,076	10,392	10,392		10
11	CAFETERIA		353,841	2,952	2,952		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION		301,955	910	910		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY		680,363	1,532	1,532		15
16	MEDICAL RECORDS & LIBRARY		424,840	2,741	2,741		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		1,953,414	23,849	23,849	50,202	30
43	NURSERY		106,287	880	880	1,777	43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,755,500	9,462	9,462	15,400	50
52	DELIVERY ROOM & LABOR ROOM		679,572	2,592	2,592	11,534	52
53	ANESTHESIOLOGY		195,977	284	284		53
54	RADIOLOGY-DIAGNOSTIC		1,906,595	7,203	7,203	10,400	54
57	CT SCAN		582,186	537	537	3,637	57
58	MRI		327,761			1,612	58
60	LABORATORY		2,110,983	5,221	5,221	3,171	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		546,500	2,746	2,746	1,868	65
66	PHYSICAL THERAPY		413,822	4,959	4,959	183	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		412,957	2,923	2,923		71
72	IMPL. DEV. CHARGED TO PATIENTS		159,250				72
73	DRUGS CHARGED TO PATIENTS		1,400,649				73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION		225,080	1,860	1,860		76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY		1,392,586	6,187	6,187	18,225	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)	-6,512,061	18,393,101	128,074	90,677	118,009	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		39,203	390	390		190
192	PHYSICIANS' PRIVATE OFFICES		400,319	10,066	10,066	3,415	192
194	OTHER NONALLOWABLE		173,138				194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I		6,512,061	455,415	1,381,429	197,952	202
203	UNIT COST MULT-WS B PT I		0.342636	3.287483	13.659528	1.630254	203
204	COST TO BE ALLOC PER B PT II		288,944	5,489	127,786	8,045	204
205	UNIT COST MULT-WS B PT II		0.015203	0.039623	1.263544	0.066255	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	DIRECT NRSING HRS	COSTED REQUIS.	
		9	10	11	13	15	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING	18,401					9
10	DIETARY		35,001				10
11	CAFETERIA			18,361			11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	124		100	7,311		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY					100	15
16	MEDICAL RECORDS & LIBRARY	23		5,764			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	3,802	35,001	3,700	3,700		30
43	NURSERY	172		109	109		43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,347		1,485	1,485		50
52	DELIVERY ROOM & LABOR ROOM	1,119		705	705		52
53	ANESTHESIOLOGY	164					53
54	RADIOLOGY-DIAGNOSTIC	1,276		1,369			54
57	CT SCAN	116		194			57
58	MRI			162			58
60	LABORATORY	971		1,261			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	462		589			65
66	PHYSICAL THERAPY	179		346			66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	144					71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS	114		373		100	73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	340		210			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,465		1,312	1,312		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)	13,818	35,001	17,679	7,311	100	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	74					190
192	PHYSICIANS' PRIVATE OFFICES	4,509		573			192
194	OTHER NONALLOWABLE			109			194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	851,848	777,717	525,108	429,438	939,442	202
203	UNIT COST MULT-WS B PT I	46.293571	22.219851	28.599096	58.738613	9,394.420000	203
204	COST TO BE ALLOC PER B PT II	18,238	64,755	17,532	31,859	26,906	204
205	UNIT COST MULT-WS B PT II	0.991142	1.850090	0.954850	4.357680	269.060000	205

COST ALLOCATION - STATISTICAL BASIS | WORKSHEET B-1

	COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY GROSS SALARIES 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	ADMITTING		5.01
5.02	PATIENT ACCOUNTING		5.02
5.03	ADMIN & GENERAL		5.03
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	81,159,803	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	6,974,272	30
43	NURSERY		43
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	7,420,479	50
52	DELIVERY ROOM & LABOR ROOM		52
53	ANESTHESIOLOGY	3,716,983	53
54	RADIOLOGY-DIAGNOSTIC	11,300,650	54
57	CT SCAN	12,586,231	57
58	MRI	5,179,820	58
60	LABORATORY	11,395,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	4,251,851	65
66	PHYSICAL THERAPY	1,603,250	66
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	846,489	71
72	IMPL. DEV. CHARGED TO PATIENTS		72
73	DRUGS CHARGED TO PATIENTS	4,637,630	73
74	RENAL DIALYSIS		74
76.97	CARDIAC REHABILITATION	296,789	76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
91	EMERGENCY	10,949,889	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)	81,159,803	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192	PHYSICIANS' PRIVATE OFFICES		192
194	OTHER NONALLOWABLE		194
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	782,769	202
203	UNIT COST MULT-WS B PT I	0.009645	203
204	COST TO BE ALLOC PER B PT II	30,444	204
205	UNIT COST MULT-WS B PT II	0.000375	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	4,452,879		4,452,879			30
43	NURSERY	177,997		177,997			43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	2,852,374		2,852,374			50
52	DELIVERY ROOM & LABOR ROOM	1,088,523		1,088,523			52
53	ANESTHESIOLOGY	311,381		311,381			53
54	RADIOLOGY-DIAGNOSTIC	2,906,106		2,906,106			54
57	CT SCAN	928,988		928,988			57
58	MRI	497,284		497,284			58
60	LABORATORY	3,118,856		3,118,856			60
62.30	BLOOD CLOTTING FOR HEMOPHIL						62.30
65	RESPIRATORY THERAPY	862,574		862,574			65
66	PHYSICAL THERAPY	673,596		673,596			66
71	MEDICAL SUPPLIES CHARGED TO	618,817		618,817			71
72	IMPL. DEV. CHARGED TO PATIE	213,815		213,815			72
73	DRUGS CHARGED TO PATIENTS	2,880,678		2,880,678			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	358,332		358,332			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	2,338,611		2,338,611			91
92	OBSERVATION BEDS (NON-DISTI	526,896		526,896			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	SUBTOTAL (SEE INSTRUCTIONS)	24,807,707		24,807,707			200
201	LESS OBSERVATION BEDS	526,896		526,896			201
202	TOTAL (SEE INSTRUCTIONS)	24,280,811		24,280,811			202

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,806,911		2,806,911				30
43	NURSERY	239,891		239,891				43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	602,362	4,853,514	5,455,876	0.522808			50
52	DELIVERY ROOM & LABOR ROOM	1,022,700	534,580	1,557,280	0.698990			52
53	ANESTHESIOLOGY	427,966	2,765,648	3,193,614	0.097501			53
54	RADIOLOGY-DIAGNOSTIC	774,208	10,450,925	11,225,133	0.258893			54
57	CT SCAN	915,159	11,196,071	12,111,230	0.076705			57
58	MRI	192,275	4,573,874	4,766,149	0.104337			58
60	LABORATORY	2,328,561	8,987,344	11,315,905	0.275617			60
62.30	BLOOD CLOTTING FOR HEMOPHIL							62.30
65	RESPIRATORY THERAPY	504,258	2,344,725	2,848,983	0.302766			65
66	PHYSICAL THERAPY	177,458	1,105,038	1,282,496	0.525223			66
71	MEDICAL SUPPLIES CHARGED TO	1,299,809	1,658,995	2,958,804	0.209144			71
72	IMPL. DEV. CHARGED TO PATIE	303,641	43,573	347,214	0.615802			72
73	DRUGS CHARGED TO PATIENTS	2,316,875	3,436,898	5,753,773	0.500659			73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION	1,069	326,790	327,859	1.092945			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	210,492	7,919,926	8,130,418	0.287637			91
92	OBSERVATION BEDS (NON-DISTI	24,546	658,969	683,515	0.770862			92
	OTHER REIMBURSABLE COST CENTERS							
94	HOME PROGRAM DIALYSIS							94
200	SUBTOTAL (SEE INSTRUCTIONS)	14,148,181	60,856,870	75,005,051				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		60,856,870	75,005,051				202

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1350)	[ ]	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	0.522808		1,808,456			945,475		50
52	DELIVERY ROOM & LABOR ROOM	0.698990							52
53	ANESTHESIOLOGY	0.097501		965,939			94,180		53
54	RADIOLOGY-DIAGNOSTIC	0.258893		4,184,798			1,083,415		54
57	CT SCAN	0.076705		5,031,738			385,959		57
58	MRI	0.104337		1,781,442			185,870		58
60	LABORATORY	0.275617		4,121,997			1,136,092		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.302766		1,198,484			362,860		65
66	PHYSICAL THERAPY	0.525223		429,274			225,465		66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144		694,390			145,228		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802		8,011			4,933		72
73	DRUGS CHARGED TO PATIENTS	0.500659		1,628,746			815,446		73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1.092945		237,630			259,717		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.287637		2,893,534			832,287		91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862		366,733			282,701		92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)			25,351,172			6,759,628		200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)			25,351,172			6,759,628		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-Z350)
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	0.522808							50
52	DELIVERY ROOM & LABOR ROOM	0.698990							52
53	ANESTHESIOLOGY	0.097501							53
54	RADIOLOGY-DIAGNOSTIC	0.258893							54
57	CT SCAN	0.076705							57
58	MRI	0.104337							58
60	LABORATORY	0.275617							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.302766							65
66	PHYSICAL THERAPY	0.525223							66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802							72
73	DRUGS CHARGED TO PATIENTS	0.500659							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1.092945							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.287637							91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	SUBTOTAL (SEE INSTRUCTIONS)								200
201	LESS PBP CLINIC LAB SERVICES								201
202	NET CHARGES (LINE 200 - LINE 201)								202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	SWING-BED ADJUSTMENT 2	REDUCED CAP-REL COST (COL.1 MINUS COL.2) 3	TOTAL PATIENT DAYS 4	PER DIEM (COL.3 ÷ COL.4) 5	INPAT PGM DAYS 6	INPAT PGM CAP COST (COL.5 x COL.6) 7	
	INPAT ROUTINE SERV COST CTRS								
30	ADULTS & PEDIATRICS	308,100	18,044	290,056	4,726	61.37	557	34,183	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	6,106		6,106	454	13.45	315	4,237	43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (LINES 30-199)	314,206		296,162	5,180		872	38,420	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1350)	[ ]	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) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	306,367	5,455,876	0.056154			50
52	DELIVERY ROOM & LABOR ROOM	26,985	1,557,280	0.017328			52
53	ANESTHESIOLOGY	72,744	3,193,614	0.022778			53
54	RADIOLOGY-DIAGNOSTIC	297,855	11,225,133	0.026535			54
57	CT SCAN	223,017	12,111,230	0.018414			57
58	MRI	38,033	4,766,149	0.007980			58
60	LABORATORY	149,087	11,315,905	0.013175			60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	79,489	2,848,983	0.027901			65
66	PHYSICAL THERAPY	42,766	1,282,496	0.033346			66
71	MEDICAL SUPPLIES CHARGED TO P	26,043	2,958,804	0.008802			71
72	IMPL. DEV. CHARGED TO PATIENT	2,421	347,214	0.006973			72
73	DRUGS CHARGED TO PATIENTS	171,534	5,753,773	0.029812			73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION	31,552	327,859	0.096236			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY	169,712	8,130,418	0.020874			91
92	OBSERVATION BEDS (NON-DISTINC	38,725	683,515	0.056656			92
	OTHER REIMBURSABLE COST CENTERS						
94	HOME PROGRAM DIALYSIS						94
200	TOTAL (SUM OF LINES 50-199)	1,676,330	71,958,249				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	4,726		557		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	454		315		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (SUM OF LINES 30-199)	5,180		872		200

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1350)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER

	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
71	MEDICAL SUPPLIES CHARGED TO P							71
72	IMPL. DEV. CHARGED TO PATIENT							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
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 (14-1350)	[ ]	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	5,455,876							50
52	DELIVERY ROOM & LABOR ROOM	1,557,280							52
53	ANESTHESIOLOGY	3,193,614							53
54	RADIOLOGY-DIAGNOSTIC	11,225,133							54
57	CT SCAN	12,111,230							57
58	MRI	4,766,149							58
60	LABORATORY	11,315,905							60
62.30	BLOOD CLOTTING FOR HEMOPHILI								62.30
65	RESPIRATORY THERAPY	2,848,983							65
66	PHYSICAL THERAPY	1,282,496							66
71	MEDICAL SUPPLIES CHARGED TO	2,958,804							71
72	IMPL. DEV. CHARGED TO PATIEN	347,214							72
73	DRUGS CHARGED TO PATIENTS	5,753,773							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	327,859							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	8,130,418							91
92	OBSERVATION BEDS (NON-DISTIN	683,515							92
	OTHER REIMBURSABLE COST CENTERS								
94	HOME PROGRAM DIALYSIS								94
200	TOTAL (SUM OF LINES 50-199)	71,958,249							200

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1350)	[ ]	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	0.522808							50
52	DELIVERY ROOM & LABOR ROOM	0.698990							52
53	ANESTHESIOLOGY	0.097501							53
54	RADIOLOGY-DIAGNOSTIC	0.258893							54
57	CT SCAN	0.076705							57
58	MRI	0.104337							58
60	LABORATORY	0.275617							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.302766							65
66	PHYSICAL THERAPY	0.525223							66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802							72
73	DRUGS CHARGED TO PATIENTS	0.500659							73
74	RENAL DIALYSIS								74
76.97	CARDIAC REHABILITATION	1.092945							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	EMERGENCY	0.287637							91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862							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 (14-1350)	[ ]	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)	5,020	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,726	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,132	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162	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)	132	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,056	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)	135	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)	110	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	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,452,879	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)	260,787	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,192,092	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)	4,192,092	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ] TITLE V-INPT	[XX]	HOSPITAL (14-1350)	[ ]	SUB (OTHER)	[ ]	PPS
APPLICABLE	[XX] TITLE XVIII-PT A	[ ]	IPF			[ ]	TEFRA
BOXES	[ ] 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)	887.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	2,710,764	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)	2,710,764	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)					2,012,762	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,723,526	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)					119,749	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					97,573	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					217,322	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)	594	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)	887.03	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)	526,896	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	308,100	4,192,092	0.073496	526,896	38,725	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 (14-1350)	[ ]	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)	5,020	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,726	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,132	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162	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)	132	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)	557	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)	454	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	315	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	132.03	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.03	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	4,452,879	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)	260,787	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	4,192,092	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)	4,192,092	37

WORKSHEET D-1
COMPUTATION OF INPATIENT OPERATING COST PART II

CHECK	[ ]	TITLE V-INPT	[XX]	HOSPITAL (14-1350)	[ ]	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)	887.03	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)	494,076	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)	494,076	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)	177,997	454	392.06	315	123,499	42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					617,575	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					38,420	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					38,420	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)	594	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 (14-1350)	[ ]	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		2,297,260		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.522808	309,827	161,980	50
52	DELIVERY ROOM & LABOR ROOM	0.698990			52
53	ANESTHESIOLOGY	0.097501	225,307	21,968	53
54	RADIOLOGY-DIAGNOSTIC	0.258893	612,778	158,644	54
57	CT SCAN	0.076705	474,345	36,385	57
58	MRI	0.104337	138,963	14,499	58
60	LABORATORY	0.275617	1,576,154	434,415	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.302766	430,781	130,426	65
66	PHYSICAL THERAPY	0.525223	115,716	60,777	66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144	947,732	198,212	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802	246,007	151,492	72
73	DRUGS CHARGED TO PATIENTS	0.500659	1,282,107	641,898	73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	1.092945	1,069	1,168	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.287637	3,121	898	91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		6,363,907	2,012,762	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		6,363,907		202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z350)	[ ]	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	0.522808			50
52	DELIVERY ROOM & LABOR ROOM	0.698990			52
53	ANESTHESIOLOGY	0.097501			53
54	RADIOLOGY-DIAGNOSTIC	0.258893	1,229	318	54
57	CT SCAN	0.076705	6,793	521	57
58	MRI	0.104337			58
60	LABORATORY	0.275617	24,259	6,686	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.302766	13,170	3,987	65
66	PHYSICAL THERAPY	0.525223	43,131	22,653	66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144	40,280	8,424	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802			72
73	DRUGS CHARGED TO PATIENTS	0.500659	51,288	25,678	73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	1.092945			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.287637			91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)		180,150	68,267	200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)		180,150		202

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-3

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1350)	[ ]	SUB (OTHER)	[ ]	S/B SNF	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.522808			50
52	DELIVERY ROOM & LABOR ROOM	0.698990			52
53	ANESTHESIOLOGY	0.097501			53
54	RADIOLOGY-DIAGNOSTIC	0.258893			54
57	CT SCAN	0.076705			57
58	MRI	0.104337			58
60	LABORATORY	0.275617			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.302766			65
66	PHYSICAL THERAPY	0.525223			66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802			72
73	DRUGS CHARGED TO PATIENTS	0.500659			73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	1.092945			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.287637			91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-3

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB (OTHER)	[XX]	S/B SNF (14-Z350)	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF	[ ]	S/B NF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF	[ ]	ICF/MR	[XX]	OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.522808			50
52	DELIVERY ROOM & LABOR ROOM	0.698990			52
53	ANESTHESIOLOGY	0.097501			53
54	RADIOLOGY-DIAGNOSTIC	0.258893			54
57	CT SCAN	0.076705			57
58	MRI	0.104337			58
60	LABORATORY	0.275617			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.302766			65
66	PHYSICAL THERAPY	0.525223			66
71	MEDICAL SUPPLIES CHARGED TO PAT	0.209144			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.615802			72
73	DRUGS CHARGED TO PATIENTS	0.500659			73
74	RENAL DIALYSIS				74
76.97	CARDIAC REHABILITATION	1.092945			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	EMERGENCY	0.287637			91
92	OBSERVATION BEDS (NON-DISTINCT	0.770862			92
	OTHER REIMBURSABLE COST CENTERS				
94	HOME PROGRAM DIALYSIS				94
200	TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202	NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

CHECK APPLICABLE BOX: [XX] HOSPITAL (14-1350) [ ] IPF [ ] IRF
[ ] SUB (OTHER) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	6,759,628	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)	6,759,628	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)	6,827,224	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)	45,434	25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	4,283,698	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,498,092	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,498,092	30
31	PRIMARY PAYER PAYMENTS	577	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,497,515	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)	1,305,282	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	1,305,282	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	1,031,632	36
37	SUBTOTAL (SEE INSTRUCTIONS) ' T4 - 10/25/13 JF	3,802,797	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R		38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (SEE INSTRUCTIONS)	3,802,797	40
40.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	19,014	40.01
41	INTERIM PAYMENTS	2,993,939	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (SEE INSTRUCTIONS)	789,844	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	171,425	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 (14-1350) [ ] 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				4,223,915		2,946,563	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE	05/16/2013	47,376	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50	05/16/2013	491,970		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		-491,970		47,376	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)				3,731,945		2,993,939	4
TO BE COMPLETED BY CONTRACTOR							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					5.01
	PROGRAM TO PROVIDER	.02					5.02
		.03					5.03
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.50					5.50
	PROVIDER TO PROGRAM	.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7

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

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

CHECK APPLICABLE BOX: [ ] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [XX] SWING BED SNF (14-Z350)

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				247,153			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01		NONE		NONE	3.01
		.02					3.02
	PROGRAM TO PROVIDER	.03					3.03
		.04					3.04
		.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50	05/16/2013	11,285		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		-11,285			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)				235,868			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					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					5.50
		.51					5.51
		.52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							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 (14-1350) [ ] CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,331	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	3,056	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	4,132	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	75,005,051	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	2,010,623	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	[ ]	TITLE V	[XX]	SWING BED - SNF (14-Z350)	
APPLICABLE	[XX]	TITLE XVIII	[ ]	SWING BED - NF	
BOXES	[ ]	TITLE XIX			

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	219,495		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)	68,950		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)			4
5	PROGRAM DAYS	245		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)	288,445		8
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			9
10	SUBTOTAL (LINE 8 MINUS LINE 9)	288,445		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)			11
12	SUBTOTAL (LINE 10 MINUS LINE 11)	288,445		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	4,793		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)	283,652		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)	283,652		19
19.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	1,418		19.01
20	INTERIM PAYMENTS	235,868		20
21	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			21
22	BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS LINES 19.01, 20 AND 21)	46,366		22
23	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	7,284		23

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1350)
APPLICABLE BOX: [ ] SUB (OTHER)

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

1	INPATIENT SERVICES	4,723,526	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	4,723,526	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	4,770,761	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)	4,770,761	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	631,116	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	4,139,645	22
23	COINSURANCE	6,978	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	4,132,667	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	214,586	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	214,586	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	130,467	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	4,347,253	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	4,347,253	30
30.01	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	21,736	30.01
31	INTERIM PAYMENTS	3,731,945	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS LINES 30.01, 31 AND 32)	593,572	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	120,740	34

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART VII

CHECK APPLICABLE BOXES:	[ ]	TITLE V	[XX]	HOSPITAL (14-1350)	[ ]	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	617,575		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)			3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	617,575		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	617,575		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS)			18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	617,575		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	617,575		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)	617,575		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)	617,575		36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			37
38	SUBTOTAL (LINE 36 ± LINE 37)	617,575		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)	617,575		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	617,575		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	2,382,170				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	5,919,701				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,916,996				6
7	INVENTORY	387,459				7
8	PREPAID EXPENSES	297,522				8
9	OTHER CURRENT ASSETS	151,315				9
10	DUE FROM OTHER FUNDS	1,306,879				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	6,528,050				11
	FIXED ASSETS					
12	LAND	99,383				12
13	LAND IMPROVEMENTS	1,766,308				13
14	ACCUMULATED DEPRECIATION	-1,050,344				14
15	BUILDINGS	16,479,667				15
16	ACCUMULATED DEPRECIATION	-4,903,435				16
17	LEASEHOLD IMPROVEMENTS	15,562,980				17
18	ACCUMULATED AMORTIZATION	-8,852,027				18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	17,935,632				23
24	ACCUMULATED DEPRECIATION	-14,495,837				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)	22,542,327				30
	OTHER ASSETS					
31	INVESTMENTS	21,694,112				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	66,031				34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	21,760,143				35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	50,830,520				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,083,239				37
38	SALARIES, WAGES & FEES PAYABLE	1,487,165				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (SHORT TERM)	1,306,879				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	1,423,034				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	5,300,317				45
	LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	8,878,816				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	7,584,050				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	16,462,866				50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	21,763,183				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	29,067,337				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)	29,067,337				59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	50,830,520				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	22,335,861								1
2	NET INCOME (LOSS) (FROM WKST G-3, LINE 29)	5,137,676								2
3	TOTAL (SUM OF LINE 1 AND LINE 2)	27,473,537								3
4	ADDITIONS (CREDIT ADJUST-MENTS)	1,593,800								4
5										5
6										6
7										7
8										8
9										9
10	TOTAL ADDITIONS (SUM OF LINES 4-9)	1,593,800								10
11	SUBTOTAL (LINE 3 PLUS LINE 10)	29,067,337								11
12	DEDUCTIONS (DEBIT ADJUST-MENTS)									12
13										13
14										14
15										15
16										16
17										17
18	TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)	29,067,337								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	4,279,977		4,279,977	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)	4,279,977		4,279,977	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)	4,279,977		4,279,977	17
18	ANCILLARY SERVICES	8,730,231	66,877,126	75,607,357	18
19	OUTPATIENT SERVICES				19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	13,010,208	66,877,126	79,887,334	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		29,868,662	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)		29,868,662	43

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	79,887,334	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	45,944,176	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	33,943,158	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	29,868,662	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	4,074,496	5
	OTHER INCOME		
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	287	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	155	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	50,546	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	200,182	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISC)	812,010	24
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,063,180	25
26	TOTAL (LINE 5 PLUS LINE 25)	5,137,676	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	5,137,676	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	OTHER ANCILLARY (SPECIFY)		CHARGES			30
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 BUILDING (SQUARE FEET) 1	CAPITAL AND RELATED COSTS EQUIPMENT (% OF TIME) 2	DIRECT PATIENT CARE SALARY RNs (HOURS) 3	DIRECT PATIENT CARE SALARY OTHER (HOURS) 4	EMPLOYEE BENEFITS DEPARTMENT (SALARY) 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	2	
1	TOTAL EXPENSES RELATED TO CARE OF PROGRAM BENEFICIARIES (SEE INSTRUCTIONS)			1
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	ADMITTING						5.01
5.02	PATIENT ACCOUNTING						5.02
5.03	ADMIN & GENERAL						5.03
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
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIAC						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
71	MEDICAL SUPPLIES CHARGED TO PA						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
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
194	OTHER NONALLOWABLE						194
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (SUM OF LINE 118 AND LINES 190-201)						202
203	TOTAL STATISTICAL BASIS						203
204	UNIT COST MULTIPLIER						204
204	UNIT COST MULTIPLIER						204