PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/23/2015 Run Time: 12:26 Version: 2015.03 (05/21/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: Time: 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the 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 WERE 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 certification 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 PRESENCE ST. JOSEPH MEDICAL CENTER (14-0007) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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)

T
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		2,013,174	60,011	65,755		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		126,249	-29			3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		2,139,423	59,982	65,755		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 333 NORTH MADISON STREET	P.O. Box:		1
2	City: JOLIET	State: IL	ZIP Code: 60435	County: CHAMPAIGN	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	PRESENCE ST. JOSEPH MEDICAL CENTER	14-0007	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	PRESENCE PSYCH	14-S007	16974	4	01 / 01 / 2013	N	P	P	4
5	Subprovider - IRF	SJMC PHYSICAL MED & REHAB	14-T007	16974	5	09 / 07 / 1987	N	P	O	5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2014	To: 12 / 31 / 2014	20
21	Type of control (see instructions)	1		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	12,037	5,809			713	1,686	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	220	351					25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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)	Y			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, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline 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 osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs 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	

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.

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 reseived 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)	N			71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)	N	N		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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N	81

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.		86

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	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. (see instructions) If yes, the GME elinination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					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
		Physical	Occupational	Speech	Respiratory	
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.					109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		1,154,138	6,407,450	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 high cost 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 cetfified 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 cetfified 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 HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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 (see instructions)	Y	148003	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: PRESENCE HEALTH	Contractor's Name: NGS	Contractor's Number: 00450	141
142	Street: 200 SOUTH WACKER DRIVE	P.O. Box:		142
143	City: CHICAGO	State: IL	ZIP Code: 60606	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 the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	Y		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	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	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. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				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. (see instructions)	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2013	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

HOSPITAL AND HOSPITAL 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)	Y			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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	06/30/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	Y		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 instructinos.	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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the padi-through date in columns 2 and 4. (see instructions)	Y	05/01/2015	Y	05/01/2015	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 Reoprt 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 HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: SANDI	Last name: COSLER	Title: SYSTEM DIRECTOR REIMBURSEM	41
42	Employer: PRESENCE HEALTH			42
43	Phone number: 815/806-2327	E-mail Address: SANDRA.COSLER@PRESENCEHEALTH.ORG		43

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 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	336	133,955			40,458	15,153	71,950	1
2	HMO and other (see instructions)						7,877	713		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider						597	46		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 instructions)		336	133,955			40,458	15,153	71,950	7
8	Intensive Care Unit	31	30	10,950			3,333	1,122	8,139	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34	18	6,570			2,946	650	6,539	11
12	Other Special Care (specify)	35								12
13	Nursery	43						2,607	4,048	13
14	Total (see instructions)		384	151,475			46,737	19,532	90,676	14
15	CAH Visits									15
16	Subprovider - IPF	40	31	11,315					7,767	16
17	Subprovider - IRF	41	31	11,315			8,561	305	11,289	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)		446							27
28	Observation Bed Days							1,593	10,749	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 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)					9,616	4,644	20,221	1
2	HMO and other (see instructions)					1,586	196		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	1.00	1,917.13			9,616	4,644	20,221	14
15	CAH Visits								15
16	Subprovider - IPF							1,514	16
17	Subprovider - IRF		13.50			691	23	906	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	1.00	1,930.63						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	127,806,205	-98,657	127,707,548	4,015,697.00	31.80	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest 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 program)			76,811	76,811	2,080.00	36.93	7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		7,108,798	3,334,500	10,443,298	189,533.00	55.10	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		8,351,653	76,811	8,428,464	212,614.00	39.64	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		1,214,269		1,214,269	10,837.00	112.05	13
14	Home office salaries & wage-related costs		22,863,080		22,863,080	512,657.00	44.60	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)(see instructions)		25,840,991		25,840,991			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		1,280,060		1,280,060			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		98,657	-98,657				26
27	Administrative & General		10,548,576		10,548,576	363,775.00	29.00	27
28	Administrative & General under contract (see instructions)		367,979		367,979	4,625.00	79.56	28
29	Maintenance & Repairs							29
30	Operation of Plant		2,854,613		2,854,613	108,260.00	26.37	30
31	Laundry & Linen Service							31
32	Housekeeping		2,466,354		2,466,354	181,359.00	13.60	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		2,593,416	-1,491,214	1,102,202	78,660.00	14.01	34
35	Dietary under contract (see instructions)		1,252,891		1,252,891	29,382.00	42.64	35
36	Cafeteria			1,491,214	1,491,214	106,446.00	14.01	36
37	Maintenance of Personnel							37
38	Nursing Administration		5,607,048		5,607,048	133,637.00	41.96	38
39	Central Services and Supply		885,476		885,476	48,633.00	18.21	39
40	Pharmacy		3,900,284	-299,105	3,601,179	88,390.00	40.74	40
41	Medical Records & Medical Records Library		2,948,836		2,948,836	125,999.00	23.40	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		129,427,075	-175,468	129,251,607	4,047,624.00	31.93	1
2	Excluded area salaries (see instructions)		7,108,798	3,334,500	10,443,298	189,533.00	55.10	2
3	Subtotal salarles (line 1 minus line 2)		122,318,277	-3,509,968	118,808,309	3,858,091.00	30.79	3
4	Subtotal other wages & related costs (see instructions)		32,429,002	76,811	32,505,813	736,108.00	44.16	4
5	Subtotal wage-related costs (see instructions)		25,840,991		25,840,991		21.75%	5
6	Total (sum of lines 3 through 5)		180,588,270	-3,433,157	177,155,113	4,594,199.00	38.56	6
7	Total overhead cost (see instructions)		33,524,130	-397,762	33,126,368	1,269,166.00	26.10	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution	2,039,423	2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	524,859	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)	12,442,863	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	288,626	10
11	Life Insurance (If employee is owner or beneficiary)	66,232	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	644,414	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	1,523,105	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	9,081,388	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	222,273	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	287,868	23
24	Total Wage Related cost (Sum of lines 1-23)	27,121,051	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date			1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)			2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month			3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)			4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan			6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date			7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)			12
13	Total Contributions Made During Averaging Period			13
14	Average Monthly Contribution (Line 13 divided by Line 12)			14
15	Number of MOnths in Provider Cost Reporting Period on Line 2			15
16	Average Pension Contributions (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)			17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

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	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	8,351,653		1
2	Hospital	8,351,653		2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.176550	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	41,001,141	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	325,271,641	6
7	Medicaid cost (line 1 times line 6)	57,426,708	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.	16,425,567	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 fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	16,425,567	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	49,551,072	3,927,128	53,478,200	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	8,748,242	693,334	9,441,576	21
22	Partial payment by patients approved for charity care	364,635	693,334	1,057,969	22
23	Cost of charity care (line 21 minus line 22)	8,383,607		8,383,607	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 length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	17,941,341	26
27	Medicare bad debts for the entire hospital complex (see instructions)	1,103,840	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	16,837,501	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,972,661	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	11,356,268	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,781,835	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		23,297,682	23,297,682	3,486,197	26,783,879	-2,534,129	24,249,750	1
2	00200	Cap Rel Costs-Mvble Equip				6,786,988	6,786,988	-170,927	6,616,061	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	98,657	27,144,631	27,243,288	-101,738	27,141,550	-468	27,141,082	4
5	00500	Administrative & General	10,548,576	69,630,660	80,179,236	-273,179	79,906,057	-6,580,755	73,325,302	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,854,613	10,881,812	13,736,425	-4,652	13,731,773	-82,366	13,649,407	7
8	00800	Laundry & Linen Service		982,957	982,957		982,957		982,957	8
9	00900	Housekeeping	2,466,354	1,352,312	3,818,666	-804	3,817,862		3,817,862	9
10	01000	Dietary	2,593,416	3,622,300	6,215,716	-3,538,654	2,677,062	-1,801,412	875,650	10
11	01100	Cafeteria				3,521,065	3,521,065		3,521,065	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	5,607,048	299,540	5,906,588	-683	5,905,905	-38,897	5,867,008	13
14	01400	Central Services & Supply	885,476	1,986,594	2,872,070	-1,222,546	1,649,524		1,649,524	14
15	01500	Pharmacy	3,900,284	16,442,256	20,342,540	-914,990	19,427,550	-176,840	19,250,710	15
16	01600	Medical Records & Library	2,948,836	1,300,629	4,249,465	-34	4,249,431	-6,103	4,243,328	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				76,811	76,811		76,811	22
23	02300	PARAMED ED PRGM-(SPECIFY)	329,320	20,938	350,258	299,105	649,363		649,363	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	36,604,342	4,351,214	40,955,556	-11,498,783	29,456,773	-133,242	29,323,531	30
31	03100	Intensive Care Unit	6,311,731	495,341	6,807,072	-373,211	6,433,861	-32,431	6,401,430	31
34	03400	Surgical Intensive Care Unit	4,200,455	390,120	4,590,575	-350,145	4,240,430		4,240,430	34
40	04000	Subprovider - IPF				4,526,545	4,526,545	-1,453,550	3,072,995	40
41	04100	Subprovider - IRF	3,195,028	200,873	3,395,901	-92,868	3,303,033		3,303,033	41
43	04300	Nursery	1,316,704	61,433	1,378,137	-42,103	1,336,034		1,336,034	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	9,853,861	31,395,893	41,249,754	-23,974,090	17,275,664	-2,156,605	15,119,059	50
54	05400	Radiology-Diagnostic	9,109,455	6,353,239	15,462,694	-3,261,624	12,201,070	-1,096,147	11,104,923	54
60	06000	Laboratory		13,910,197	13,910,197	-173,293	13,736,904	-133,935	13,602,969	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	2,320,248	582,653	2,902,901	-278,336	2,624,565	-7,368	2,617,197	65
66	06600	Physical Therapy	7,254,122	2,526,072	9,780,194	-288,430	9,491,764	-29,024	9,462,740	66
69	06900	Electrocardiology	3,274,391	7,961,769	11,236,160	-7,853,352	3,382,808	-98,736	3,284,072	69
70	07000	Electroencephalography	340,276	25,811	366,087	-18,821	347,266		347,266	70
71	07100	Medical Supplies Charged to Patients				16,213,262	16,213,262		16,213,262	71
72	07200	Impl. Dev. Charged to Patients				24,488,644	24,488,644		24,488,644	72
73	07300	Drugs Charged to Patients								73
76	03950	OTHER ANCILLARY	462,663	114,778	577,441	5,490,152	6,067,593	-14,283	6,053,310	76
76.10	03550	OUTPATIENT PSYCH	337,104	17,825	354,929	-388	354,541		354,541	76.10
76.97	07697	CARDIAC REHABILITATION	498,204	4,806	503,010	-1,886	501,124	-1,768	499,356	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	6,910,591	1,880,360	8,790,951	-592,513	8,198,438	-69,634	8,128,804	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		9,956,371	9,956,371	-9,956,371				113
118		SUBTOTALS (sum of lines 1-117)	124,221,755	237,191,066	361,412,821	75,275	361,488,096	-16,618,620	344,869,476	118
		NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	3,584,450	9,408,230	12,992,680	-75,275	12,917,405		12,917,405	192.01
200		TOTAL (sum of lines 118-199)	127,806,205	246,599,296	374,405,501		374,405,501	-16,618,620	357,786,881	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS CAFETERIA COSTS	A	Cafeteria	11	1,491,214	2,029,851	1
500	Total reclassifications				1,491,214	2,029,851	500
	Code Letter - A						
1	RECLASS CAPITAL INSURANCE	B	Cap Rel Costs-Bldg & Fixt	1		194,302	1
2	RECLASS CAPITAL INSURANCE	B	Cap Rel Costs-Mvble Equip	2		59,073	2
500	Total reclassifications					253,375	500
	Code Letter - B						
1	RECLASS INTEREST EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		9,956,371	1
500	Total reclassifications					9,956,371	500
	Code Letter - C						
1	RECLASS MEDICAL SUPPLIES	D	Medical Supplies Charged to P	71		16,213,262	1
2	RECLASS MEDICAL SUPPLIES	D	Impl. Dev. Charged to Patient	72		24,488,644	2
3	RECLASS MEDICAL SUPPLIES	D					3
4	RECLASS MEDICAL SUPPLIES	D					4
5	RECLASS MEDICAL SUPPLIES	D					5
6	RECLASS MEDICAL SUPPLIES	D					6
7	RECLASS MEDICAL SUPPLIES	D					7
8	RECLASS MEDICAL SUPPLIES	D					8
9	RECLASS MEDICAL SUPPLIES	D					9
10	RECLASS MEDICAL SUPPLIES	D					10
11	RECLASS MEDICAL SUPPLIES	D					11
12	RECLASS MEDICAL SUPPLIES	D					12
13	RECLASS MEDICAL SUPPLIES	D					13
14	RECLASS MEDICAL SUPPLIES	D					14
15	RECLASS MEDICAL SUPPLIES	D					15
16	RECLASS MEDICAL SUPPLIES	D					16
17	RECLASS MEDICAL SUPPLIES	D					17
18	RECLASS MEDICAL SUPPLIES	D					18
19	RECLASS MEDICAL SUPPLIES	D					19
20	RECLASS MEDICAL SUPPLIES	D					20
21	RECLASS MEDICAL SUPPLIES	D					21
22	RECLASS MEDICAL SUPPLIES	D					22
23	RECLASS MEDICAL SUPPLIES	D					23
24	RECLASS MEDICAL SUPPLIES	D					24
25	RECLASS MEDICAL SUPPLIES	D					25
26	RECLASS MEDICAL SUPPLIES	D					26
500	Total reclassifications					40,701,906	500
	Code Letter - D						
1	RECLASS MOVABLE EQ DEPRECIATION	E	Cap Rel Costs-Mvble Equip	2		6,727,915	1
2	RECLASS MOVABLE EQ DEPRECIATION	E	Cap Rel Costs-Bldg & Fixt	1		63,439	2
500	Total reclassifications					6,791,354	500
	Code Letter - E						
1	RECLASS IV THERAPY	F	OTHER ANCILLARY	76	4,914,796	584,229	1
500	Total reclassifications				4,914,796	584,229	500
	Code Letter - F						
1	RECLASS PHARMARCIST TEACHING	G	PARAMED ED PRGM-(SPECIFY)	23	299,105		1
500	Total reclassifications				299,105		500
	Code Letter - G						
1	RECLASS RESIDENT COSTS	H	I&R Services-Other Prgm Costs	22		76,811	1
500	Total reclassifications					76,811	500
	Code Letter - H						
1	RECLASS BENEFIT DOLLARS TO NONWAGE	I	Administrative & General	5		98,657	1
500	Total reclassifications					98,657	500
	Code Letter - I						
1	RECLASS PSYCH COSTS	J	Subprovider - IPF	40	3,035,395	1,491,150	1
500	Total reclassifications				3,035,395	1,491,150	500
	Code Letter - J						
	GRAND TOTAL (Increases)				9,740,510	61,983,704	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASS CAFETERIA COSTS	A	Dietary	10	1,491,214	2,029,851		1
500	Total reclassifications				1,491,214	2,029,851		500
	Code letter - A							
1	RECLASS CAPITAL INSURANCE	B	Administrative & General	5		194,302	12	1
2	RECLASS CAPITAL INSURANCE	B	Administrative & General	5		59,073	12	2
500	Total reclassifications					253,375		500
	Code letter - B							
1	RECLASS INTEREST EXPENSE	C	Interest Expense	113		9,956,371	11	1
500	Total reclassifications					9,956,371		500
	Code letter - C							
1	RECLASS MEDICAL SUPPLIES	D	Employee Benefits Department	4		3,081		1
2	RECLASS MEDICAL SUPPLIES	D	Administrative & General	5		41,650		2
3	RECLASS MEDICAL SUPPLIES	D	Operation of Plant	7		4,652		3
4	RECLASS MEDICAL SUPPLIES	D	Housekeeping	9		804		4
5	RECLASS MEDICAL SUPPLIES	D	Dietary	10		17,589		5
6	RECLASS MEDICAL SUPPLIES	D	Nursing Administration	13		683		6
7	RECLASS MEDICAL SUPPLIES	D	Central Services & Supply	14		1,222,546		7
8	RECLASS MEDICAL SUPPLIES	D	Pharmacy	15		615,885		8
9	RECLASS MEDICAL SUPPLIES	D	Medical Records & Library	16		34		9
10	RECLASS MEDICAL SUPPLIES	D	Adults & Pediatrics	30		1,473,213		10
11	RECLASS MEDICAL SUPPLIES	D	Intensive Care Unit	31		373,211		11
12	RECLASS MEDICAL SUPPLIES	D	Surgical Intensive Care Unit	34		350,145		12
13	RECLASS MEDICAL SUPPLIES	D	Subprovider - IRF	41		92,868		13
14	RECLASS MEDICAL SUPPLIES	D	Nursery	43		42,103		14
15	RECLASS MEDICAL SUPPLIES	D	Operating Room	50		23,974,090		15
16	RECLASS MEDICAL SUPPLIES	D	Radiology-Diagnostic	54		3,261,624		16
17	RECLASS MEDICAL SUPPLIES	D	Laboratory	60		173,293		17
18	RECLASS MEDICAL SUPPLIES	D	Respiratory Therapy	65		278,336		18
19	RECLASS MEDICAL SUPPLIES	D	Physical Therapy	66		288,430		19
20	RECLASS MEDICAL SUPPLIES	D	Electrocardiology	69		7,853,352		20
21	RECLASS MEDICAL SUPPLIES	D	Electroencephalography	70		18,821		21
22	RECLASS MEDICAL SUPPLIES	D	OTHER ANCILLARY	76		8,873		22
23	RECLASS MEDICAL SUPPLIES	D	OUTPATIENT PSYCH	76.10		388		23
24	RECLASS MEDICAL SUPPLIES	D	CARDIAC REHABILITATION	76.97		1,886		24
25	RECLASS MEDICAL SUPPLIES	D	Emergency	91		592,513		25
26	RECLASS MEDICAL SUPPLIES	D	OTHER NRCC	192.01		11,836		26
500	Total reclassifications					40,701,906		500
	Code letter - D							
1	RECLASS MOVABLE EQ DEPRECIATION	E	Cap Rel Costs-Bldg & Fixt	1		6,727,915	9	1
2	RECLASS MOVABLE EQ DEPRECIATION	E	OTHER NRCC	192.01		63,439	9	2
500	Total reclassifications					6,791,354		500
	Code letter - E							
1	RECLASS IV THERAPY	F	Adults & Pediatrics	30	4,914,796	584,229		1
500	Total reclassifications				4,914,796	584,229		500
	Code letter - F							
1	RECLASS PHARMARCIST TEACHING	G	Pharmacy	15	299,105			1
500	Total reclassifications				299,105			500
	Code letter - G							
1	RECLASS RESIDENT COSTS	H	Administrative & General	5		76,811		1
500	Total reclassifications					76,811		500
	Code letter - H							
1	RECLASS BENEFIT DOLLARS TO NONWAGE	I	Employee Benefits Department	4	98,657			1
500	Total reclassifications				98,657			500
	Code letter - I							
1	RECLASS PSYCH COSTS	J	Adults & Pediatrics	30	3,035,395	1,491,150		1
500	Total reclassifications				3,035,395	1,491,150		500
	Code letter - J							
	GRAND TOTAL (Decreases)				9,839,167	61,885,047		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	1,884,595					1,884,595		1
2	Land Improvements	3,208,539	82,133		82,133	1,333,182	1,957,490		2
3	Buildings and Fixtures	331,941,605	2,670,827		2,670,827	918,998	333,693,434		3
4	Building Improvements	1,439,521					1,439,521		4
5	Fixed Equipment								5
6	Movable Equipment	128,563,049	7,985,620		7,985,620	9,379,102	127,169,567		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	467,037,309	10,738,580		10,738,580	11,631,282	466,144,607		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	467,037,309	10,738,580		10,738,580	11,631,282	466,144,607		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	23,297,682						23,297,682	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	23,297,682						23,297,682	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	337,535,519		337,535,519	0.724100					1
2	Cap Rel Costs-Mvble Equ	128,609,088		128,609,088	0.275900					2
3	Total (sum of lines 1-2)	466,144,607		466,144,607	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	14,099,077		9,956,371	194,302			24,249,750	1
2	Cap Rel Costs-Mvble Equip	6,556,988			59,073			6,616,061	2
3	Total (sum of lines 1-2)	20,656,065		9,956,371	253,375			30,865,811	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	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	Trace, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-6,090,119				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-7,253,665				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests						14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						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						32
33	MISC INCOME	B	-468	Employee Benefits Department	4		33
34	MISC INCOME	B	-581,912	Administrative & General	5		34
35	MISC INCOME	B	-82,366	Operation of Plant	7		35
36	MISC INCOME	B	-1,801,412	Dietary	10		36
37	MISC INCOME	B	-3,334	Nursing Administration	13		37
38	MISC INCOME	B	-152,113	Pharmacy	15		38
39	MISC INCOME	B	-6,103	Medical Records & Library	16		39
40	MISC INCOME	B	-32,108	Adults & Pediatrics	30		40
41	MISC INCOME	B	-28	Operating Room	50		41
42	MISC INCOME	B	-14,773	Radiology-Diagnostic	54		42
43	MISC INCOME	B	-24,768	Laboratory	60		43
44	MISC INCOME	B	-29,024	Physical Therapy	66		44
44.01	MISC INCOME	B	-8,860	Electrocardiology	69		44.01
44.02	MISC INCOME	B	-1,768	CARDIAC REHABILITATION	76.97		44.02
44.03	MISC INCOME	B	-385	Emergency	91		44.03
45	NONALLOWABLE EXP	A	-269	Administrative & General	5		45
46	MARKETING OFFSET	A	-279,676	Administrative & General	5		46
47							47
47.01	NRCC DEPR EXPENSE	A	-63,439	Cap Rel Costs-Mvble Equip	2	9	47.01
48	PATIENT TRANSPORTATION	A	-192,030	Administrative & General	5		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-16,618,620				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	INTEREST	7,374,210	9,908,339	-2,534,129	9	1
2	2	Cap Rel Costs-Mvble Equip	DEPRECIATION	5,159,267	5,266,755	-107,488	9	2
3	5	Administrative & General	ADMINISTRATION	26,220,207	48,850,271	-22,630,064		3
3.01	5	Administrative & General	IT	12,083,547		12,083,547		3.01
3.02	5	Administrative & General	CBO	4,397,234		4,397,234		3.02
3.03	5	Administrative & General	EICU	905,448		905,448		3.03
3.04	5	Administrative & General	ESICU	610,619		610,619		3.04
4	60	Laboratory	ALVERNO LAB	11,256,722	11,235,554	21,168		4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			68,007,254	75,260,919	-7,253,665		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B	PROVENA HEALTH	100.00				6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen ADMINISTRATIVE	1,008,662	831,255	177,407	177,200	1,350	115,010	5,751	1
2	13	Nursing Administrati NURSING ADMINIS	35,563	35,563						2
3	15	Pharmacy PHARMACY	27,027	20,356	6,671	177,200	27	2,300	115	3
4	30	Adults & Pediatrics ADULTS & PEDIAT	488,077	10,294	477,783	177,200	4,542	386,943	19,347	4
5	31	Intensive Care Unit INTENSIVE CARE	56,029	680	55,349	177,200	277	23,598	1,180	5
6	41	Subprovider - IRF SUBPROVIDER - I	64,167		64,167	177,200	880	74,969	3,748	6
7	50	Operating Room OPERATING ROOM	2,156,577	2,156,577						7
8	54	Radiology-Diagnostic RADIOLOGY-DIAGN	1,081,374	1,081,374						8
9	60	Laboratory LABORATORY	130,335	130,335						9
10	65	Respiratory Therapy RESPIRATORY THE	32,500	3,000	29,500	177,200	295	25,132	1,257	10
11	69	Electrocardiology ELECTROCARDIOLO	166,625	3,864	162,761	165,600	964	76,749	3,837	11
12	76	OTHER ANCILLARY OTHER ANCILLARY	15,000	14,150	850	165,600	9	717	36	12
13	91	Emergency EMERGENCY	309,030	69,249	239,781	208,000	2,493	249,300	12,465	13
14	40	Subprovider - IPF PSYCH	1,453,550	1,453,550						14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	7,024,516	5,810,247	1,214,269		10,837	954,718	47,736	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE					115,010	62,397	893,652	1
2	13	Nursing Administrati NURSING ADMINIS							35,563	2
3	15	Pharmacy PHARMACY					2,300	4,371	24,727	3
4	30	Adults & Pediatrics ADULTS & PEDIAT					386,943	90,840	101,134	4
5	31	Intensive Care Unit INTENSIVE CARE					23,598	31,751	32,431	5
6	41	Subprovider - IRF SUBPROVIDER - I					74,969			6
7	50	Operating Room OPERATING ROOM							2,156,577	7
8	54	Radiology-Diagnostic RADIOLOGY-DIAGN							1,081,374	8
9	60	Laboratory LABORATORY							130,335	9
10	65	Respiratory Therapy RESPIRATORY THE					25,132	4,368	7,368	10
11	69	Electrocardiology ELECTROCARDIOLO					76,749	86,012	89,876	11
12	76	OTHER ANCILLARY OTHER ANCILLARY					717	133	14,283	12
13	91	Emergency EMERGENCY					249,300		69,249	13
14	40	Subprovider - IPF PSYCH							1,453,550	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					954,718	279,872	6,090,119	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	24,249,750	24,249,750					1
2	Cap Rel Costs-Mvble Equip	6,616,061		6,616,061				2
4	Employee Benefits Department	27,141,082	100,413	3,466	27,244,961			4
5	Administrative & General	73,325,302	6,008,525	1,335,504	2,250,423	82,919,754	82,919,754	5
6	Maintenance & Repairs							6
7	Operation of Plant	13,649,407	3,547,664	2,391,227	609,000	20,197,298	6,092,959	7
8	Laundry & Linen Service	982,957	141,296	391		1,124,644	339,274	8
9	Housekeeping	3,817,862	265,942	41,879	526,169	4,651,852	1,403,333	9
10	Dietary	875,650	217,232	38,952	235,143	1,366,977	412,379	10
11	Cafeteria	3,521,065	295,607	18,889	318,134	4,153,695	1,253,053	11
12	Maintenance of Personnel							12
13	Nursing Administration	5,867,008	127,839	57,342	1,196,202	7,248,391	2,186,637	13
14	Central Services & Supply	1,649,524	511,376	62,725	188,907	2,412,532	727,793	14
15	Pharmacy	19,250,710	69,484	7,778	768,272	20,096,244	6,062,474	15
16	Medical Records & Library	4,243,328	235,479	9,541	629,102	5,117,450	1,543,791	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	76,811				76,811	23,172	22
23	PARAMED ED PRGM-(SPECIFY)	649,363	5,321	70	134,068	788,822	237,966	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	29,323,531	5,327,604	277,044	6,113,009	41,041,188	12,381,018	30
31	Intensive Care Unit	6,401,430	607,067	77,781	1,346,538	8,432,816	2,543,944	31
34	Surgical Intensive Care Unit	4,240,430	481,689	52,011	896,121	5,670,251	1,710,556	34
40	Subprovider - IPF	3,072,995	583,654	27,037	647,568	4,331,254	1,306,618	40
41	Subprovider - IRF	3,303,033	379,015	9,410	681,624	4,373,082	1,319,236	41
43	Nursery	1,336,034	180,473	11,890	280,904	1,809,301	545,815	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,119,059	1,776,481	673,725	2,102,213	19,671,478	5,934,334	50
54	Radiology-Diagnostic	11,104,923	950,497	746,275	1,943,402	14,745,097	4,448,183	54
60	Laboratory	13,602,969	285,675	10,684		13,899,328	4,193,038	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,617,197	48,732	22,047	494,999	3,182,975	960,214	65
66	Physical Therapy	9,462,740	183,133	51,574	1,547,587	11,245,034	3,392,312	66
69	Electrocardiology	3,284,072	381,764	275,519	698,555	4,639,910	1,399,731	69
70	Electroencephalography	347,266	100,236	13,642	72,594	533,738	161,014	70
71	Medical Supplies Charged to Patients	16,213,262				16,213,262	4,891,087	71
72	Impl. Dev. Charged to Patients	24,488,644				24,488,644	7,387,538	72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY	6,053,310	93,052	2,182	1,147,222	7,295,766	2,200,928	76
76.10	OUTPATIENT PSYCH	354,541	7,006	1,516	71,917	434,980	131,221	76.10
76.97	CARDIAC REHABILITATION	499,356	131,231	2,720	106,286	739,593	223,114	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	8,128,804	701,139	98,506	1,474,299	10,402,748	3,138,218	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	344,869,476	23,744,626	6,321,327	26,480,258	343,304,915	78,550,950	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	12,917,405	505,124	294,734	764,703	14,481,966	4,368,804	192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	357,786,881	24,249,750	6,616,061	27,244,961	357,786,881	82,919,754	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	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	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	26,290,257						7
8	Laundry & Linen Service	254,552	1,718,470					8
9	Housekeeping	479,108		6,534,293				9
10	Dietary	391,355		100,061	2,270,772			10
11	Cafeteria	532,551		136,162		6,075,461		11
12	Maintenance of Personnel							12
13	Nursing Administration	230,307		58,885		255,546	9,979,766	13
14	Central Services & Supply	921,269		235,549		92,991		14
15	Pharmacy	125,179		32,006		169,038		15
16	Medical Records & Library	424,227		108,466		240,949		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)	9,586		2,451		40,967		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,597,936	1,126,780	2,453,992	1,526,465	1,744,828	4,433,082	30
31	Intensive Care Unit	1,093,660	127,462	279,626	174,876	303,672	771,538	31
34	Surgical Intensive Care Unit	867,786	102,405	221,875	140,498	233,909	594,291	34
40	Subprovider - IPF	1,051,481	121,636	268,842	166,885	170,748	433,819	40
41	Subprovider - IRF	682,813	176,793	174,581	242,561	202,686	514,965	41
43	Nursery	325,130	63,394	83,129		53,694	136,421	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,200,416		818,280		467,499	1,187,774	50
54	Radiology-Diagnostic	1,712,366		437,817		504,886		54
60	Laboratory	514,656		131,587				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	87,793		22,447		149,907		65
66	Physical Therapy	329,923		84,355		354,821		66
69	Electrocardiology	687,766		175,848		169,356		69
70	Electroencephalography	180,579		46,170		22,830		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY	167,638		42,862		318,865	810,140	76
76.10	OUTPATIENT PSYCH	12,622		3,227		20,205	51,335	76.10
76.97	CARDIAC REHABILITATION	236,418		60,447		27,484		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,263,135		322,958	19,487	411,856	1,046,401	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	25,380,252	1,718,470	6,301,623	2,270,772	5,956,737	9,979,766	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	910,005		232,670		118,724		192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,290,257	1,718,470	6,534,293	2,270,772	6,075,461	9,979,766	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	22	23	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	4,390,134						14
15	Pharmacy		26,484,941					15
16	Medical Records & Library			7,434,883				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				99,983			22
23	PARAMED ED PRGM-(SPECIFY)					1,079,792		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			702,232	49,991		75,057,512	30
31	Intensive Care Unit			167,582			13,895,176	31
34	Surgical Intensive Care Unit			121,049			9,662,620	34
40	Subprovider - IPF			55,049			7,906,332	40
41	Subprovider - IRF			79,577			7,766,294	41
43	Nursery			35,060			3,051,944	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			659,427	49,992		31,989,200	50
54	Radiology-Diagnostic			1,419,871			23,268,220	54
60	Laboratory			981,195			19,719,804	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			159,110			4,562,446	65
66	Physical Therapy			238,157			15,644,602	66
69	Electrocardiology			469,283			7,541,894	69
70	Electroencephalography			20,541			964,872	70
71	Medical Supplies Charged to Patients	1,748,779		548,512			23,401,640	71
72	Impl. Dev. Charged to Patients	2,641,355		407,482			34,925,019	72
73	Drugs Charged to Patients		26,484,941	621,629		1,079,792	28,186,362	73
76	OTHER ANCILLARY			141,814			10,978,013	76
76.10	OUTPATIENT PSYCH			5,110			658,700	76.10
76.97	CARDIAC REHABILITATION			8,418			1,295,474	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency			593,785			17,198,588	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	4,390,134	26,484,941	7,434,883	99,983	1,079,792	337,674,712	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC						20,112,169	192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,390,134	26,484,941	7,434,883	99,983	1,079,792	357,786,881	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		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	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	-49,991	75,007,521					30
31	Intensive Care Unit		13,895,176					31
34	Surgical Intensive Care Unit		9,662,620					34
40	Subprovider - IPF		7,906,332					40
41	Subprovider - IRF		7,766,294					41
43	Nursery		3,051,944					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	-49,992	31,939,208					50
54	Radiology-Diagnostic		23,268,220					54
60	Laboratory		19,719,804					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,562,446					65
66	Physical Therapy		15,644,602					66
69	Electrocardiology		7,541,894					69
70	Electroencephalography		964,872					70
71	Medical Supplies Charged to Patients		23,401,640					71
72	Impl. Dev. Charged to Patients		34,925,019					72
73	Drugs Charged to Patients		28,186,362					73
76	OTHER ANCILLARY		10,978,013					76
76.10	OUTPATIENT PSYCH		658,700					76.10
76.97	CARDIAC REHABILITATION		1,295,474					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		17,198,588					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	-99,983	337,574,729					118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC		20,112,169					192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	-99,983	357,686,898					202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		100,413	3,466	103,879	103,879		4
5	Administrative & General		6,008,525	1,335,504	7,344,029	8,576	7,352,605	5
6	Maintenance & Repairs							6
7	Operation of Plant		3,547,664	2,391,227	5,938,891	2,321	540,278	7
8	Laundry & Linen Service		141,296	391	141,687		30,084	8
9	Housekeeping		265,942	41,879	307,821	2,005	124,437	9
10	Dietary		217,232	38,952	256,184	896	36,567	10
11	Cafeteria		295,607	18,889	314,496	1,212	111,111	11
12	Maintenance of Personnel							12
13	Nursing Administration		127,839	57,342	185,181	4,559	193,894	13
14	Central Services & Supply		511,376	62,725	574,101	720	64,535	14
15	Pharmacy		69,484	7,778	77,262	2,928	537,575	15
16	Medical Records & Library		235,479	9,541	245,020	2,397	136,892	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						2,055	22
23	PARAMED ED PRGM-(SPECIFY)		5,321	70	5,391	511	21,101	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		5,327,604	277,044	5,604,648	23,349	1,097,759	30
31	Intensive Care Unit		607,067	77,781	684,848	5,131	225,578	31
34	Surgical Intensive Care Unit		481,689	52,011	533,700	3,415	151,679	34
40	Subprovider - IPF		583,654	27,037	610,691	2,468	115,861	40
41	Subprovider - IRF		379,015	9,410	388,425	2,598	116,980	41
43	Nursery		180,473	11,890	192,363	1,070	48,399	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,776,481	673,725	2,450,206	8,011	526,212	50
54	Radiology-Diagnostic		950,497	746,275	1,696,772	7,406	394,431	54
60	Laboratory		285,675	10,684	296,359		371,807	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		48,732	22,047	70,779	1,886	85,145	65
66	Physical Therapy		183,133	51,574	234,707	5,898	300,805	66
69	Electrocardiology		381,764	275,519	657,283	2,662	124,118	69
70	Electroencephalography		100,236	13,642	113,878	277	14,277	70
71	Medical Supplies Charged to Patients						433,705	71
72	Impl. Dev. Charged to Patients						655,071	72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY		93,052	2,182	95,234	4,372	195,162	76
76.10	OUTPATIENT PSYCH		7,006	1,516	8,522	274	11,636	76.10
76.97	CARDIAC REHABILITATION		131,231	2,720	133,951	405	19,784	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		701,139	98,506	799,645	5,618	278,274	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		23,744,626	6,321,327	30,065,953	100,965	6,965,212	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC		505,124	294,734	799,858	2,914	387,393	192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		24,249,750	6,616,061	30,865,811	103,879	7,352,605	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	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	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	6,481,490						7
8	Laundry & Linen Service	62,756	234,527					8
9	Housekeeping	118,117		552,380				9
10	Dietary	96,483		8,459	398,589			10
11	Cafeteria	131,293		11,511		569,623		11
12	Maintenance of Personnel							12
13	Nursing Administration	56,779		4,978		23,959	469,350	13
14	Central Services & Supply	227,126		19,912		8,719		14
15	Pharmacy	30,861		2,706		15,849		15
16	Medical Records & Library	104,587		9,169		22,591		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)	2,363		207		3,841		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,366,235	153,776	207,450	267,940	163,592	208,488	30
31	Intensive Care Unit	269,626	17,395	23,638	30,696	28,472	36,286	31
34	Surgical Intensive Care Unit	213,940	13,976	18,756	24,662	21,931	27,950	34
40	Subprovider - IPF	259,228	16,600	22,727	29,293	16,009	20,403	40
41	Subprovider - IRF	168,338	24,128	14,758	42,577	19,003	24,219	41
43	Nursery	80,156	8,652	7,027		5,034	6,416	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	789,017		69,174		43,832	55,861	50
54	Radiology-Diagnostic	422,160		37,011		47,337		54
60	Laboratory	126,881		11,124				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	21,644		1,898		14,055		65
66	Physical Therapy	81,338		7,131		33,267		66
69	Electrocardiology	169,559		14,865		15,878		69
70	Electroencephalography	44,519		3,903		2,141		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY	41,329		3,623		29,896	38,101	76
76.10	OUTPATIENT PSYCH	3,112		273		1,894	2,414	76.10
76.97	CARDIAC REHABILITATION	58,286		5,110		2,577		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	311,408		27,301	3,421	38,615	49,212	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	6,257,141	234,527	532,711	398,589	558,492	469,350	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	224,349		19,669		11,131		192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,481,490	234,527	552,380	398,589	569,623	469,350	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL	
		14	15	16	22	23	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	895,113						14
15	Pharmacy		667,181					15
16	Medical Records & Library			520,656				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				2,055			22
23	PARAMED ED PRGM-(SPECIFY)					33,414		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			49,127			10,142,364	30
31	Intensive Care Unit			11,724			1,333,394	31
34	Surgical Intensive Care Unit			8,468			1,018,477	34
40	Subprovider - IPF			3,851			1,097,131	40
41	Subprovider - IRF			5,567			806,593	41
43	Nursery			2,453			351,570	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			46,133			3,988,446	50
54	Radiology-Diagnostic			99,855			2,704,972	54
60	Laboratory			68,643			874,814	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			11,131			206,538	65
66	Physical Therapy			16,661			679,807	66
69	Electrocardiology			32,831			1,017,196	69
70	Electroencephalography			1,437			180,432	70
71	Medical Supplies Charged to Patients	356,562		38,373			828,640	71
72	Impl. Dev. Charged to Patients	538,551		28,507			1,222,129	72
73	Drugs Charged to Patients		667,181	43,488			710,669	73
76	OTHER ANCILLARY			9,921			417,638	76
76.10	OUTPATIENT PSYCH			357			28,482	76.10
76.97	CARDIAC REHABILITATION			589			220,702	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency			41,540			1,555,034	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	895,113	667,181	520,656			29,385,028	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC						1,445,314	192.01
200	Cross Foot Adjustments				2,055	33,414	35,469	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	895,113	667,181	520,656	2,055	33,414	30,865,811	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		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	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		10,142,364					30
31	Intensive Care Unit		1,333,394					31
34	Surgical Intensive Care Unit		1,018,477					34
40	Subprovider - IPF		1,097,131					40
41	Subprovider - IRF		806,593					41
43	Nursery		351,570					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,988,446					50
54	Radiology-Diagnostic		2,704,972					54
60	Laboratory		874,814					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		206,538					65
66	Physical Therapy		679,807					66
69	Electrocardiology		1,017,196					69
70	Electroencephalography		180,432					70
71	Medical Supplies Charged to Patients		828,640					71
72	Impl. Dev. Charged to Patients		1,222,129					72
73	Drugs Charged to Patients		710,669					73
76	OTHER ANCILLARY		417,638					76
76.10	OUTPATIENT PSYCH		28,482					76.10
76.97	CARDIAC REHABILITATION		220,702					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		1,555,034					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		29,385,028					118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC		1,445,314					192.01
200	Cross Foot Adjustments		35,469					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		30,865,811					202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,093,755						1
2	Cap Rel Costs-Mvble Equip		16,510,560					2
4	Employee Benefits Department	4,529	8,650	127,707,548				4
5	Administrative & General	271,007	3,332,786	10,548,576	-82,919,754	274,867,127		5
6	Maintenance & Repairs							6
7	Operation of Plant	160,013	5,967,374	2,854,613		20,197,298	658,206	7
8	Laundry & Linen Service	6,373	975			1,124,644	6,373	8
9	Housekeeping	11,995	104,509	2,466,354		4,651,852	11,995	9
10	Dietary	9,798	97,207	1,102,202		1,366,977	9,798	10
11	Cafeteria	13,333	47,138	1,491,214		4,153,695	13,333	11
12	Maintenance of Personnel							12
13	Nursing Administration	5,766	143,099	5,607,048		7,248,391	5,766	13
14	Central Services & Supply	23,065	156,533	885,476		2,412,532	23,065	14
15	Pharmacy	3,134	19,410	3,601,179		20,096,244	3,134	15
16	Medical Records & Library	10,621	23,811	2,948,836		5,117,450	10,621	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					76,811		22
23	PARAMED ED PRGM-(SPECIFY)	240	175	628,425		788,822	240	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	240,295	691,370	28,654,151		41,041,188	240,295	30
31	Intensive Care Unit	27,381	194,105	6,311,731		8,432,816	27,381	31
34	Surgical Intensive Care Unit	21,726	129,796	4,200,455		5,670,251	21,726	34
40	Subprovider - IPF	26,325	67,471	3,035,395		4,331,254	26,325	40
41	Subprovider - IRF	17,095	23,482	3,195,028		4,373,082	17,095	41
43	Nursery	8,140	29,671	1,316,704		1,809,301	8,140	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	80,126	1,681,298	9,853,861		19,671,478	80,126	50
54	Radiology-Diagnostic	42,871	1,862,349	9,109,455		14,745,097	42,871	54
60	Laboratory	12,885	26,661			13,899,328	12,885	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,198	55,019	2,320,248		3,182,975	2,198	65
66	Physical Therapy	8,260	128,705	7,254,122		11,245,034	8,260	66
69	Electrocardiology	17,219	687,566	3,274,391		4,639,910	17,219	69
70	Electroencephalography	4,521	34,044	340,276		533,738	4,521	70
71	Medical Supplies Charged to Patients					16,213,262		71
72	Impl. Dev. Charged to Patients					24,488,644		72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY	4,197	5,445	5,377,459		7,295,766	4,197	76
76.10	OUTPATIENT PSYCH	316	3,782	337,104		434,980	316	76.10
76.97	CARDIAC REHABILITATION	5,919	6,787	498,204		739,593	5,919	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	31,624	245,825	6,910,591		10,402,748	31,624	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,070,972	15,775,043	124,123,098	-82,919,754	260,385,161	635,423	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	22,783	735,517	3,584,450		14,481,966	22,783	192.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	24,249,750	6,616,061	27,244,961		82,919,754	26,290,257	202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.171099	0.400717	0.213339		0.301672	39.942293	203
204	Cost to be allocated (Per Wkst. B, Part II)			103,879		7,352,605	6,481,490	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000813		0.026750	9.847206	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	109,732						8
9	Housekeeping		639,838					9
10	Dietary		9,798	434,765				10
11	Cafeteria		13,333		152,751			11
12	Maintenance of Personnel							12
13	Nursing Administration		5,766		6,425	98,758		13
14	Central Services & Supply		23,065		2,338		40,701,906	14
15	Pharmacy		3,134		4,250			15
16	Medical Records & Library		10,621		6,058			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)		240		1,030			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	71,950	240,295	292,259	43,869	43,869		30
31	Intensive Care Unit	8,139	27,381	33,482	7,635	7,635		31
34	Surgical Intensive Care Unit	6,539	21,726	26,900	5,881	5,881		34
40	Subprovider - IPF	7,767	26,325	31,952	4,293	4,293		40
41	Subprovider - IRF	11,289	17,095	46,441	5,096	5,096		41
43	Nursery	4,048	8,140		1,350	1,350		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		80,126		11,754	11,754		50
54	Radiology-Diagnostic		42,871		12,694			54
60	Laboratory		12,885					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,198		3,769			65
66	Physical Therapy		8,260		8,921			66
69	Electrocardiology		17,219		4,258			69
70	Electroencephalography		4,521		574			70
71	Medical Supplies Charged to Patients						16,213,262	71
72	Impl. Dev. Charged to Patients						24,488,644	72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY		4,197		8,017	8,017		76
76.10	OUTPATIENT PSYCH		316		508	508		76.10
76.97	CARDIAC REHABILITATION		5,919		691			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		31,624	3,731	10,355	10,355		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	109,732	617,055	434,765	149,766	98,758	40,701,906	118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC		22,783		2,985			192.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,718,470	6,534,293	2,270,772	6,075,461	9,979,766	4,390,134	202
203	Unit Cost Multiplier (Wkst. B, Part I)	15.660609	10.212418	5.222987	39.773625	101.052735	0.107861	203
204	Cost to be allocated (Per Wkst. B, Part II)	234,527	552,380	398,589	569,623	469,350	895,113	204
205	Unit Cost Multiplier (Wkst. B, Part II)	2.137271	0.863312	0.916792	3.729095	4.752526	0.021992	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		15	16	22	23			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	13,702,449						15
16	Medical Records & Library		1,912,060,830					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			100				22
23	PARAMED ED PRGM-(SPECIFY)				100			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		180,615,151	50				30
31	Intensive Care Unit		43,102,356					31
34	Surgical Intensive Care Unit		31,133,976					34
40	Subprovider - IPF		14,158,735					40
41	Subprovider - IRF		20,467,294					41
43	Nursery		9,017,545					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		169,605,601	50				50
54	Radiology-Diagnostic		364,989,458					54
60	Laboratory		252,365,088					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		40,923,359					65
66	Physical Therapy		61,254,487					66
69	Electrocardiology		120,700,458					69
70	Electroencephalography		5,283,185					70
71	Medical Supplies Charged to Patients		141,078,308					71
72	Impl. Dev. Charged to Patients		104,805,148					72
73	Drugs Charged to Patients	13,702,449	159,883,985		100			73
76	OTHER ANCILLARY		36,474,796					76
76.10	OUTPATIENT PSYCH		1,314,333					76.10
76.97	CARDIAC REHABILITATION		2,165,181					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		152,722,386					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,702,449	1,912,060,830	100	100			118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC							192.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	26,484,941	7,434,883	99,983	1,079,792			202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.932862	0.003888	999.830000	10,797.920000			203
204	Cost to be allocated (Per Wkst. B, Part II)	667,181	520,656	2,055	33,414			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.048691	0.000272	20.550000	334.140000			205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	75,007,521		75,007,521	90,840	75,098,361	30
31	Intensive Care Unit	13,895,176		13,895,176	31,751	13,926,927	31
34	Surgical Intensive Care Unit	9,662,620		9,662,620		9,662,620	34
40	Subprovider - IPF	7,906,332		7,906,332		7,906,332	40
41	Subprovider - IRF	7,766,294		7,766,294		7,766,294	41
43	Nursery	3,051,944		3,051,944		3,051,944	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	31,939,208		31,939,208		31,939,208	50
54	Radiology-Diagnostic	23,268,220		23,268,220		23,268,220	54
60	Laboratory	19,719,804		19,719,804		19,719,804	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,562,446		4,562,446	4,368	4,566,814	65
66	Physical Therapy	15,644,602		15,644,602		15,644,602	66
69	Electrocardiology	7,541,894		7,541,894	86,012	7,627,906	69
70	Electroencephalography	964,872		964,872		964,872	70
71	Medical Supplies Charged to Patients	23,401,640		23,401,640		23,401,640	71
72	Impl. Dev. Charged to Patients	34,925,019		34,925,019		34,925,019	72
73	Drugs Charged to Patients	28,186,362		28,186,362		28,186,362	73
76	OTHER ANCILLARY	10,978,013		10,978,013	133	10,978,146	76
76.10	OUTPATIENT PSYCH	658,700		658,700		658,700	76.10
76.97	CARDIAC REHABILITATION	1,295,474		1,295,474		1,295,474	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	17,198,588		17,198,588		17,198,588	91
92	Observation Beds (Non-Distinct Part)	9,761,059		9,761,059		9,761,059	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	347,335,788		347,335,788	213,104	347,548,892	200
201	Less Observation Beds	9,761,059		9,761,059		9,761,059	201
202	Total (line 200 minus line 201)	337,574,729		337,574,729		337,787,833	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	156,951,824		156,951,824				30
31	Intensive Care Unit	43,102,356		43,102,356				31
34	Surgical Intensive Care Unit	31,133,976		31,133,976				34
40	Subprovider - IPF	14,158,735		14,158,735				40
41	Subprovider - IRF	20,467,294		20,467,294				41
43	Nursery	9,017,545		9,017,545				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	75,253,954	94,351,647	169,605,601	0.188315	0.188315	0.188315	50
54	Radiology-Diagnostic	124,306,281	240,683,177	364,989,458	0.063750	0.063750	0.063750	54
60	Laboratory	128,254,546	124,110,542	252,365,088	0.078140	0.078140	0.078140	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	36,874,190	4,049,169	40,923,359	0.111488	0.111488	0.111594	65
66	Physical Therapy	32,004,658	29,249,829	61,254,487	0.255403	0.255403	0.255403	66
69	Electrocardiology	53,590,723	67,109,735	120,700,458	0.062484	0.062484	0.063197	69
70	Electroencephalography	1,593,475	3,689,710	5,283,185	0.182631	0.182631	0.182631	70
71	Medical Supplies Charged to Patients	90,909,094	50,169,214	141,078,308	0.165877	0.165877	0.165877	71
72	Impl. Dev. Charged to Patients	70,577,805	34,227,343	104,805,148	0.333238	0.333238	0.333238	72
73	Drugs Charged to Patients	125,215,184	34,668,801	159,883,985	0.176293	0.176293	0.176293	73
76	OTHER ANCILLARY	3,902,146	32,572,650	36,474,796	0.300975	0.300975	0.300979	76
76.10	OUTPATIENT PSYCH	795,923	518,410	1,314,333	0.501167	0.501167	0.501167	76.10
76.97	CARDIAC REHABILITATION	8,297	2,156,884	2,165,181	0.598321	0.598321	0.598321	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	51,792,227	100,930,159	152,722,386	0.112613	0.112613	0.112613	91
92	Observation Beds (Non-Distinct Part)	6,684,590	16,978,737	23,663,327	0.412497	0.412497	0.412497	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	1,076,594,823	835,466,007	1,912,060,830				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	1,076,594,823	835,466,007	1,912,060,830				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V **[XX] PPS**
[XX] Title XVIII, Part A **[ ] TEFRA**
[ ] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	10,142,364		10,142,364	82,699	122.64	40,458	4,961,769	30
31	Intensive Care Unit	1,333,394		1,333,394	8,139	163.83	3,333	546,045	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	1,018,477		1,018,477	6,539	155.75	2,946	458,840	34
35	Other Special Care (specify)								35
40	Subprovider - IPF	1,097,131		1,097,131	7,767	141.26			40
41	Subprovider - IRF	806,593		806,593	11,289	71.45	8,561	611,683	41
42	Subprovider I								42
43	Nursery	351,570		351,570	4,048	86.85			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	14,749,529		14,749,529	120,481		55,298	6,578,337	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other)
[XX] PPS **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516	31,756,384	746,783	50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411	68,712,379	509,227	54
60	Laboratory	874,814	252,365,088	0.003466	66,293,656	229,774	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047	19,633,894	99,092	65
66	Physical Therapy	679,807	61,254,487	0.011098	9,712,751	107,792	66
69	Electrocardiology	1,017,196	120,700,458	0.008427	30,521,357	257,203	69
70	Electroencephalography	180,432	5,283,185	0.034152	799,246	27,296	70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874	41,036,557	241,049	71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661	32,908,424	383,745	72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445	62,560,107	278,080	73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450	1,697,033	19,431	76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670	136,264	2,953	76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932	5,297	540	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182	26,440,247	269,215	91
92	Observation Beds (Non-Distinct Part)	1,318,270	23,663,327	0.055709	3,973,363	221,352	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	15,953,769	1,637,229,100		396,186,959	3,393,532	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V **[XX] PPS**
[XX] Title XVIII, Part A **[ ] TEFRA**
[ ] Title XIX **[ ] Other**

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	82,699		40,458		30
31	Intensive Care Unit	8,139		3,333		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	6,539		2,946		34
35	Other Special Care (specify)					35
40	Subprovider - IPF	7,767				40
41	Subprovider - IRF	11,289		8,561		41
42	Subprovider I					42
43	Nursery	4,048				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	120,481		55,298		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [XX] Title XVIII, Part A | [ ] Title XIX | [XX] Hospital | [ ] IPF | [ ] IRF | [ ] SUB (Other) | [ ] SNF | [ ] NF | [ ] ICF/MR | [XX] PPS | [ ] TEFRA | [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601			31,756,384		25,172,005		50
54	Radiology-Diagnostic	364,989,458			68,712,379		54,670,781		54
60	Laboratory	252,365,088			66,293,656		16,983,597		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359			19,633,894		890,596		65
66	Physical Therapy	61,254,487			9,712,751		3,321,100		66
69	Electrocardiology	120,700,458			30,521,357		26,764,784		69
70	Electroencephalography	5,283,185			799,246		903,179		70
71	Medical Supplies Charged to Patients	141,078,308			41,036,557		16,862,654		71
72	Impl. Dev. Charged to Patients	104,805,148			32,908,424		12,871,679		72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754	62,560,107	422,531	10,694,078	72,228	73
76	OTHER ANCILLARY	36,474,796			1,697,033		9,761,323		76
76.10	OUTPATIENT PSYCH	1,314,333			136,264		466		76.10
76.97	CARDIAC REHABILITATION	2,165,181			5,297		1,079,867		76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386			26,440,247		16,495,578		91
92	Observation Beds (Non-Distinct Part)	23,663,327			3,973,363		6,209,622		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100			396,186,959	422,531	202,681,309	72,228	200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[XX] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[ ] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315	25,172,005			4,740,266			50
54	Radiology-Diagnostic	0.063750	54,670,781			3,485,262			54
60	Laboratory	0.078140	16,983,597	2,307		1,327,098	180		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488	890,596			99,291			65
66	Physical Therapy	0.255403	3,321,100			848,219			66
69	Electrocardiology	0.062484	26,764,784			1,672,371			69
70	Electroencephalography	0.182631	903,179			164,948			70
71	Medical Supplies Charged to Patients	0.165877	16,862,654	11,304		2,797,126	1,875		71
72	Impl. Dev. Charged to Patients	0.333238	12,871,679			4,289,333			72
73	Drugs Charged to Patients	0.176293	10,694,078	25	65,852	1,885,291	4	11,609	73
76	OTHER ANCILLARY	0.300975	9,761,323			2,937,914			76
76.10	OUTPATIENT PSYCH	0.501167	466			234			76.10
76.97	CARDIAC REHABILITATION	0.598321	1,079,867			646,107			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613	16,495,578			1,857,617			91
92	Observation Beds (Non-Distinct Part)	0.412497	6,209,622			2,561,450			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		202,681,309	13,636	65,852	29,312,527	2,059	11,609	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		202,681,309	13,636	65,852	29,312,527	2,059	11,609	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[XX] Title XVIII, Part A **[XX] IPF** **[ ] TEFRA**
[ ] Title XIX **[ ] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516			50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411			54
60	Laboratory	874,814	252,365,088	0.003466			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047			65
66	Physical Therapy	679,807	61,254,487	0.011098			66
69	Electrocardiology	1,017,196	120,700,458	0.008427			69
70	Electroencephalography	180,432	5,283,185	0.034152			70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874			71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661			72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445			73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450			76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670			76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182			91
92	Observation Beds (Non-Distinct Part)		23,663,327				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,635,499	1,637,229,100				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [XX] Title XVIII, Part A | [ ] Title XIX
[ ] Hospital | [XX] IPF | [ ] IRF
[ ] SUB (Other) | [ ] SNF | [ ] NF
[ ] ICF/MR
[XX] PPS | [ ] TEFRA | [ ] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S007** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [XX] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601							50
54	Radiology-Diagnostic	364,989,458							54
60	Laboratory	252,365,088							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359							65
66	Physical Therapy	61,254,487							66
69	Electrocardiology	120,700,458							69
70	Electroencephalography	5,283,185							70
71	Medical Supplies Charged to Patients	141,078,308							71
72	Impl. Dev. Charged to Patients	104,805,148							72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754					73
76	OTHER ANCILLARY	36,474,796							76
76.10	OUTPATIENT PSYCH	1,314,333							76.10
76.97	CARDIAC REHABILITATION	2,165,181							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386							91
92	Observation Beds (Non-Distinct Part)	23,663,327							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100							200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[XX] Title XVIII, Part B	[XX] IPF	[ ] SNF	[ ] Swing Bed NF
[ ] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315							50
54	Radiology-Diagnostic	0.063750							54
60	Laboratory	0.078140							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488							65
66	Physical Therapy	0.255403							66
69	Electrocardiology	0.062484							69
70	Electroencephalography	0.182631							70
71	Medical Supplies Charged to Patients	0.165877							71
72	Impl. Dev. Charged to Patients	0.333238							72
73	Drugs Charged to Patients	0.176293							73
76	OTHER ANCILLARY	0.300975							76
76.10	OUTPATIENT PSYCH	0.501167							76.10
76.97	CARDIAC REHABILITATION	0.598321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613							91
92	Observation Beds (Non-Distinct Part)	0.412497							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[XX] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[ ] Title XIX **[XX] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516	66,958	1,575	50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411	1,215,676	9,009	54
60	Laboratory	874,814	252,365,088	0.003466	3,353,160	11,622	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047	815,984	4,118	65
66	Physical Therapy	679,807	61,254,487	0.011098	12,187,298	135,255	66
69	Electrocardiology	1,017,196	120,700,458	0.008427	360,071	3,034	69
70	Electroencephalography	180,432	5,283,185	0.034152	25,032	855	70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874	1,020,847	5,996	71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661			72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445	3,927,781	17,459	73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450			76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670			76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182	25,524	260	91
92	Observation Beds (Non-Distinct Part)		23,663,327				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,635,499	1,637,229,100		22,998,331	189,183	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [XX] Title XVIII, Part A | [ ] Title XIX | [ ] Hospital | [ ] IPF | [XX] IRF | [ ] SUB (Other) | [ ] SNF | [ ] NF | [ ] ICF/MR | [XX] PPS | [ ] TEFRA | [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/MR [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX [XX] IRF [ ] NF [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601			66,958				50
54	Radiology-Diagnostic	364,989,458			1,215,676		23,655		54
60	Laboratory	252,365,088			3,353,160		606		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359			815,984		109		65
66	Physical Therapy	61,254,487			12,187,298				66
69	Electrocardiology	120,700,458			360,071		965		69
70	Electroencephalography	5,283,185			25,032				70
71	Medical Supplies Charged to Patients	141,078,308			1,020,847		9,279		71
72	Impl. Dev. Charged to Patients	104,805,148							72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754	3,927,781	26,528	1,440	10	73
76	OTHER ANCILLARY	36,474,796							76
76.10	OUTPATIENT PSYCH	1,314,333							76.10
76.97	CARDIAC REHABILITATION	2,165,181							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386			25,524				91
92	Observation Beds (Non-Distinct Part)	23,663,327							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100			22,998,331	26,528	36,054	10	200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[XX] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[ ] Title XIX - O/P	[XX] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315							50
54	Radiology-Diagnostic	0.063750	23,655			1,508			54
60	Laboratory	0.078140	606			47			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488	109			12			65
66	Physical Therapy	0.255403							66
69	Electrocardiology	0.062484	965			60			69
70	Electroencephalography	0.182631							70
71	Medical Supplies Charged to Patients	0.165877	9,279	257		1,539	43		71
72	Impl. Dev. Charged to Patients	0.333238							72
73	Drugs Charged to Patients	0.176293	1,440		3,400	254		599	73
76	OTHER ANCILLARY	0.300975							76
76.10	OUTPATIENT PSYCH	0.501167							76.10
76.97	CARDIAC REHABILITATION	0.598321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613							91
92	Observation Beds (Non-Distinct Part)	0.412497							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		36,054	257	3,400	3,420	43	599	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		36,054	257	3,400	3,420	43	599	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	10,142,364		10,142,364	82,699	122.64	15,153	1,858,364	30
31	Intensive Care Unit	1,333,394		1,333,394	8,139	163.83	1,122	183,817	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit	1,018,477		1,018,477	6,539	155.75	650	101,238	34
35	Other Special Care (specify)								35
40	Subprovider - IPF	1,097,131		1,097,131	7,767	141.26			40
41	Subprovider - IRF	806,593		806,593	11,289	71.45	305	21,792	41
42	Subprovider I								42
43	Nursery	351,570		351,570	4,048	86.85	2,607	226,418	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	14,749,529		14,749,529	120,481		19,837	2,391,629	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[XX] Hospital** **[ ] SUB (Other)**
[ ] Title XVIII, Part A **[ ] IPF**
[XX] Title XIX **[ ] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516			50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411			54
60	Laboratory	874,814	252,365,088	0.003466			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047			65
66	Physical Therapy	679,807	61,254,487	0.011098			66
69	Electrocardiology	1,017,196	120,700,458	0.008427			69
70	Electroencephalography	180,432	5,283,185	0.034152			70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874			71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661			72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445			73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450			76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670			76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182			91
92	Observation Beds (Non-Distinct Part)	1,318,270	23,663,327	0.055709			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	15,953,769	1,637,229,100				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V **[ ] PPS**
[ ] Title XVIII, Part A **[ ] TEFRA**
[XX] Title XIX **[XX] Other**

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	82,699		15,153		30
31	Intensive Care Unit	8,139		1,122		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit	6,539		650		34
35	Other Special Care (specify)					35
40	Subprovider - IPF	7,767				40
41	Subprovider - IRF	11,289		305		41
42	Subprovider I					42
43	Nursery	4,048		2,607		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	120,481		19,837		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0007** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601							50
54	Radiology-Diagnostic	364,989,458							54
60	Laboratory	252,365,088							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359							65
66	Physical Therapy	61,254,487							66
69	Electrocardiology	120,700,458							69
70	Electroencephalography	5,283,185							70
71	Medical Supplies Charged to Patients	141,078,308							71
72	Impl. Dev. Charged to Patients	104,805,148							72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754					73
76	OTHER ANCILLARY	36,474,796							76
76.10	OUTPATIENT PSYCH	1,314,333							76.10
76.97	CARDIAC REHABILITATION	2,165,181							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386							91
92	Observation Beds (Non-Distinct Part)	23,663,327							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100							200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315							50
54	Radiology-Diagnostic	0.063750							54
60	Laboratory	0.078140							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488							65
66	Physical Therapy	0.255403							66
69	Electrocardiology	0.062484							69
70	Electroencephalography	0.182631							70
71	Medical Supplies Charged to Patients	0.165877							71
72	Impl. Dev. Charged to Patients	0.333238							72
73	Drugs Charged to Patients	0.176293							73
76	OTHER ANCILLARY	0.300975							76
76.10	OUTPATIENT PSYCH	0.501167							76.10
76.97	CARDIAC REHABILITATION	0.598321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613							91
92	Observation Beds (Non-Distinct Part)	0.412497							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[ ] Title XVIII, Part A **[XX] IPF** **[ ] TEFRA**
[XX] Title XIX **[ ] IRF**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516			50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411			54
60	Laboratory	874,814	252,365,088	0.003466			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047			65
66	Physical Therapy	679,807	61,254,487	0.011098			66
69	Electrocardiology	1,017,196	120,700,458	0.008427			69
70	Electroencephalography	180,432	5,283,185	0.034152			70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874			71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661			72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445			73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450			76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670			76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182			91
92	Observation Beds (Non-Distinct Part)		23,663,327				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,635,499	1,637,229,100				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/MR [XX] PPS
[ ] Title XVIII, Part A [XX] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [ ] Title XVIII, Part A | [XX] Title XIX | [ ] Hospital | [XX] IPF | [ ] IRF | [ ] SUB (Other) | [ ] SNF | [ ] NF | [ ] ICF/MR | [XX] PPS | [ ] TEFRA | [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601							50
54	Radiology-Diagnostic	364,989,458							54
60	Laboratory	252,365,088							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359							65
66	Physical Therapy	61,254,487							66
69	Electrocardiology	120,700,458							69
70	Electroencephalography	5,283,185							70
71	Medical Supplies Charged to Patients	141,078,308							71
72	Impl. Dev. Charged to Patients	104,805,148							72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754					73
76	OTHER ANCILLARY	36,474,796							76
76.10	OUTPATIENT PSYCH	1,314,333							76.10
76.97	CARDIAC REHABILITATION	2,165,181							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386							91
92	Observation Beds (Non-Distinct Part)	23,663,327							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100							200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[XX] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[ ] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315							50
54	Radiology-Diagnostic	0.063750							54
60	Laboratory	0.078140							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488							65
66	Physical Therapy	0.255403							66
69	Electrocardiology	0.062484							69
70	Electroencephalography	0.182631							70
71	Medical Supplies Charged to Patients	0.165877							71
72	Impl. Dev. Charged to Patients	0.333238							72
73	Drugs Charged to Patients	0.176293							73
76	OTHER ANCILLARY	0.300975							76
76.10	OUTPATIENT PSYCH	0.501167							76.10
76.97	CARDIAC REHABILITATION	0.598321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613							91
92	Observation Beds (Non-Distinct Part)	0.412497							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T007** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other)
[ ] Title XVIII, Part A [ ] IPF
[XX] Title XIX [XX] IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516			50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411			54
60	Laboratory	874,814	252,365,088	0.003466			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047			65
66	Physical Therapy	679,807	61,254,487	0.011098			66
69	Electrocardiology	1,017,196	120,700,458	0.008427			69
70	Electroencephalography	180,432	5,283,185	0.034152			70
71	Medical Supplies Charged to Patients	828,640	141,078,308	0.005874			71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661			72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445			73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450			76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670			76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182			91
92	Observation Beds (Non-Distinct Part)		23,663,327				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	14,635,499	1,637,229,100				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [XX] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			1,079,792		1,079,792	1,079,792	73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)			1,079,792		1,079,792	1,079,792	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T007** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [XX] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	169,605,601							50
54	Radiology-Diagnostic	364,989,458							54
60	Laboratory	252,365,088							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	40,923,359							65
66	Physical Therapy	61,254,487							66
69	Electrocardiology	120,700,458							69
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72	Impl. Dev. Charged to Patients	104,805,148							72
73	Drugs Charged to Patients	159,883,985	0.006754	0.006754					73
76	OTHER ANCILLARY	36,474,796							76
76.10	OUTPATIENT PSYCH	1,314,333							76.10
76.97	CARDIAC REHABILITATION	2,165,181							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	152,722,386							91
92	Observation Beds (Non-Distinct Part)	23,663,327							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	1,637,229,100							200

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[XX] IRF	[ ] NF	[ ] ICF/MR

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.188315							50
54	Radiology-Diagnostic	0.063750							54
60	Laboratory	0.078140							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.111488							65
66	Physical Therapy	0.255403							66
69	Electrocardiology	0.062484							69
70	Electroencephalography	0.182631							70
71	Medical Supplies Charged to Patients	0.165877							71
72	Impl. Dev. Charged to Patients	0.333238							72
73	Drugs Charged to Patients	0.176293							73
76	OTHER ANCILLARY	0.300975							76
76.10	OUTPATIENT PSYCH	0.501167							76.10
76.97	CARDIAC REHABILITATION	0.598321							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.112613							91
92	Observation Beds (Non-Distinct Part)	0.412497							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	82,699	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	82,699	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	71,950	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	40,458	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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	75,098,361	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	75,098,361	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	75,098,361	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0007** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) | [XX] PPS [ ] TEFRA [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	908.09	38
39	Program general inpatient routine service cost (line 9 x line 38)	36,739,505	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)	36,739,505	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	13,926,927	8,139	1,711.13	3,333	5,703,196	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit	9,662,620	6,539	1,477.69	2,946	4,353,275	46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	56,288,333	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	103,084,309	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	5,966,654	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,816,063	51
52	Total Program excludable cost (sum of lines 50 and 51)	9,782,717	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	93,301,592	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					10,749	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					908.09	88
89	Observation bed cost (line 87 x line 88) (see instructions)					9,761,059	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	10,142,364	75,098,361	0.135054	9,761,059	1,318,270	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[XX] PPS
	[XX] Title XVIII, Part A	[XX] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,767	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,767	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,767	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		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 XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,906,332	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,906,332	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	7,906,332	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S007** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[XX] PPS
	[XX] Title XVIII, Part A	[XX] IPF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF		[ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,017.94	38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)		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 (sum of lines 50 and 51)		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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[XX] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,289	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,289	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,289	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,561	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 XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,766,294	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,766,294	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	7,766,294	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T007** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF		[ ] TEFRA
	[ ] Title XIX - I/P	[XX] IRF		[ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	687.95	38
39	Program general inpatient routine service cost (line 9 x line 38)	5,889,540	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)	5,889,540	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	4,447,831	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	10,337,371	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	611,683	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	215,711	51
52	Total Program excludable cost (sum of lines 50 and 51)	827,394	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	9,509,977	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[ ] PPS	
	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA	
	[XX] Title XIX - I/P	[ ] IRF	[ ] NF		[XX] Other	

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	82,699	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	82,699	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	71,950	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	15,153	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 XIX only)	4,048	15
16	Nursery days (title V or XIX only)	2,607	16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	75,007,521	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	75,007,521	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	75,007,521	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0007** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	906.99	38
39	Program general inpatient routine service cost (line 9 x line 38)	13,743,619	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)	13,743,619	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)	3,051,944	4,048	753.94	2,607	1,965,522	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	13,895,176	8,139	1,707.23	1,122	1,915,512	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit	9,662,620	6,539	1,477.69	650	960,499	46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	18,585,152	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,369,837	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 (sum of lines 50 and 51)	2,369,837	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					10,749	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
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[XX] PPS
	[ ] Title XVIII, Part A	[XX] IPF	[ ] SNF		[ ] TEFRA
	[XX] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,767	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,767	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	7,767	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		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 XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,906,332	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,906,332	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	7,906,332	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S007** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[XX] PPS
	[ ] Title XVIII, Part A	[XX] IPF		[ ] TEFRA
	[XX] Title XIX - I/P	[ ] IRF		[ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,017.94	38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)		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 (sum of lines 50 and 51)		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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T007** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[ ] PPS
	[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[XX] Title XIX - I/P	[XX] IRF	[ ] NF		[XX] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,289	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,289	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	11,289	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	305	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 XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,766,294	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,766,294	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation 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 minus line 36)	7,766,294	37

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] PPS
	[ ] Title XVIII, Part A	[ ] IPF		[ ] TEFRA
	[XX] Title XIX - I/P	[XX] IRF		[XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	687.95	38
39	Program general inpatient routine service cost (line 9 x line 38)	209,825	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)	209,825	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	209,825	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	21,792	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 (sum of lines 50 and 51)	21,792	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0007** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/MR**
[XX] PPS **[ ] TEFRA** **[ ] Other**

(A)	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		78,936,307		30
31	Intensive Care Unit		20,978,245		31
34	Surgical Intensive Care Unit		17,115,589		34
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315	31,756,384	5,980,203	50
54	Radiology-Diagnostic	0.063750	68,712,379	4,380,414	54
60	Laboratory	0.078140	66,293,656	5,180,186	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111594	19,633,894	2,191,025	65
66	Physical Therapy	0.255403	9,712,751	2,480,666	66
69	Electrocardiology	0.063197	30,521,357	1,928,858	69
70	Electroencephalography	0.182631	799,246	145,967	70
71	Medical Supplies Charged to Patients	0.165877	41,036,557	6,807,021	71
72	Impl. Dev. Charged to Patients	0.333238	32,908,424	10,966,337	72
73	Drugs Charged to Patients	0.176293	62,560,107	11,028,909	73
76	OTHER ANCILLARY	0.300979	1,697,033	510,771	76
76.10	OUTPATIENT PSYCH	0.501167	136,264	68,291	76.10
76.97	CARDIAC REHABILITATION	0.598321	5,297	3,169	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613	26,440,247	2,977,516	91
92	Observation Beds (Non-Distinct Part)	0.412497	3,973,363	1,639,000	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		396,186,959	56,288,333	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		396,186,959		202

(A) Worksheet A line numbers

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34	Surgical Intensive Care Unit				34
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315			50
54	Radiology-Diagnostic	0.063750			54
60	Laboratory	0.078140			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111594			65
66	Physical Therapy	0.255403			66
69	Electrocardiology	0.063197			69
70	Electroencephalography	0.182631			70
71	Medical Supplies Charged to Patients	0.165877			71
72	Impl. Dev. Charged to Patients	0.333238			72
73	Drugs Charged to Patients	0.176293			73
76	OTHER ANCILLARY	0.300979			76
76.10	OUTPATIENT PSYCH	0.501167			76.10
76.97	CARDIAC REHABILITATION	0.598321			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613			91
92	Observation Beds (Non-Distinct Part)	0.412497			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T007** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[XX] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34	Surgical Intensive Care Unit				34
40	Subprovider - IPF				40
41	Subprovider - IRF		15,690,648		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315	66,958	12,609	50
54	Radiology-Diagnostic	0.063750	1,215,676	77,499	54
60	Laboratory	0.078140	3,353,160	262,016	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111594	815,984	91,059	65
66	Physical Therapy	0.255403	12,187,298	3,112,672	66
69	Electrocardiology	0.063197	360,071	22,755	69
70	Electroencephalography	0.182631	25,032	4,572	70
71	Medical Supplies Charged to Patients	0.165877	1,020,847	169,335	71
72	Impl. Dev. Charged to Patients	0.333238			72
73	Drugs Charged to Patients	0.176293	3,927,781	692,440	73
76	OTHER ANCILLARY	0.300979			76
76.10	OUTPATIENT PSYCH	0.501167			76.10
76.97	CARDIAC REHABILITATION	0.598321			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613	25,524	2,874	91
92	Observation Beds (Non-Distinct Part)	0.412497			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		22,998,331	4,447,831	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		22,998,331		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0007** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34	Surgical Intensive Care Unit				34
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315			50
54	Radiology-Diagnostic	0.063750			54
60	Laboratory	0.078140			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111488			65
66	Physical Therapy	0.255403			66
69	Electrocardiology	0.062484			69
70	Electroencephalography	0.182631			70
71	Medical Supplies Charged to Patients	0.165877			71
72	Impl. Dev. Charged to Patients	0.333238			72
73	Drugs Charged to Patients	0.176293			73
76	OTHER ANCILLARY	0.300975			76
76.10	OUTPATIENT PSYCH	0.501167			76.10
76.97	CARDIAC REHABILITATION	0.598321			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613			91
92	Observation Beds (Non-Distinct Part)	0.412497			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S007** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[ ] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34	Surgical Intensive Care Unit				34
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315			50
54	Radiology-Diagnostic	0.063750			54
60	Laboratory	0.078140			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111594			65
66	Physical Therapy	0.255403			66
69	Electrocardiology	0.063197			69
70	Electroencephalography	0.182631			70
71	Medical Supplies Charged to Patients	0.165877			71
72	Impl. Dev. Charged to Patients	0.333238			72
73	Drugs Charged to Patients	0.176293			73
76	OTHER ANCILLARY	0.300979			76
76.10	OUTPATIENT PSYCH	0.501167			76.10
76.97	CARDIAC REHABILITATION	0.598321			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613			91
92	Observation Beds (Non-Distinct Part)	0.412497			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[XX] IRF	[ ] NF	[ ] ICF/MR	[XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
34	Surgical Intensive Care Unit				34
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.188315			50
54	Radiology-Diagnostic	0.063750			54
60	Laboratory	0.078140			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.111488			65
66	Physical Therapy	0.255403			66
69	Electrocardiology	0.062484			69
70	Electroencephalography	0.182631			70
71	Medical Supplies Charged to Patients	0.165877			71
72	Impl. Dev. Charged to Patients	0.333238			72
73	Drugs Charged to Patients	0.176293			73
76	OTHER ANCILLARY	0.300975			76
76.10	OUTPATIENT PSYCH	0.501167			76.10
76.97	CARDIAC REHABILITATION	0.598321			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.112613			91
92	Observation Beds (Non-Distinct Part)	0.412497			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	60,415,407			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	20,084,912			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	1,911,237			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				
3	Managed care simulated payments	13,293,663			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	385.55			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	9.00			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	5.85			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	5.85			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	9.00			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	1.00			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	1.00			12
13	Total allowable FTE count for the prior year	0.94			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1.04			14
15	Sum of lines 12 through 14 divided by 3	0.99			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	0.99			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.002568			19
20	Prior year resident to bed ratio (see instructions)	0.002847			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.002568			21
22	IME payment adjustment (see instructions)	131,593			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	-8.00			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	131,593			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0397			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2233			31
32	Sum of lines 30 and 31	0.2630			32
33	Allowable disproportionate share percentage (see instructions)	0.0946			33
34	Disproportionate share adjustment (see instructions)	1,903,833			34
		Prior to	**On or after**		
	Uncompensated Care Adjustment	**October 1**	**October 1**		
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	4,457,416	3,819,984		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,333,902	962,846		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,296,748			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	88,743,730			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	88,743,730			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	7,070,449			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	49,749			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	21,156			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)	422,531			58
59	Total (sum of amounts on lines 49 through 58)	96,307,615			59
60	Primary payer payments	14,917			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	96,292,698			61
62	Deductibles billed to program beneficiaries	7,578,784			62
63	Coinsurance billed to program beneficiaries	483,048			63
64	Allowable bad debts (see instructions)	1,151,549			64
65	Adjusted reimbursable bad debts (see instructions)	748,507			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,027,213			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	88,979,373			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	46,950			70.93
70.94	HRR adjustment amount (see instructions)	-1,202,292			70.94
71	Amount due provider (see instructions)	87,824,031			71
71.01	Sequestration adjustment (see instructions)	1,756,481			71.01
72	Interim payments	84,054,376			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	2,013,174			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	92,574			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1							1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges							2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage							10
11	Disproportionate share adjustment							11
11.01	Uncompensated care payments							11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal							13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only							15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)							16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**							19
20	Capital DRG other than outlier							20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments							21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments							26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment							30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment							31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment							32

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	13,668			1
2	Medical and other services reimbursed under OPPS (see instructions)	29,240,299			2
3	PPS payments	28,742,494			3
4	Outlier payment (see instructions)	22,141			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	72,228			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	13,668			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	79,488			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	79,488			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	79,488			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	65,820			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)	13,668			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	28,836,863			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	2,261			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	5,756,145			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	23,092,125			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	12,862			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	23,104,987			30
31	Primary payer payments	11,687			31
32	Subtotal (line 30 minus line 31)	23,093,300			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)	546,362			34
35	Adjusted reimbursable bad debts (see instructions)	355,135			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	531,392			36
37	Subtotal (see instructions)	23,448,435			37
38	MSP-LCC reconciliation amount from PS&R	45			38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	23,448,390			40
40.01	Sequestration adjustment (see instructions)	468,968			40.01
41	Interim payments	22,919,411			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	60,011			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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

PRESENCE ST. JOSEPH MEDICAL CENTER Provider CCN: 14-0007	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/23/2015 Run Time: 12:26 Version: 2015.03 (05/21/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T007** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	642			1
2	Medical and other services reimbursed under OPPS (see instructions)	3,410			2
3	PPS payments	2,784			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	10			9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	642			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	3,657			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	3,657			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	3,657			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	3,015			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)	642			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,794			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	51			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	452			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,933			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)	2,933			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,933			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	2,933			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,933			40
40.01	Sequestration adjustment (see instructions)	59			40.01
41	Interim payments	2,903			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-29			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse 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

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				83,353,812		22,543,067	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				599,613		367,426	2
3	List separately each retroactive lump sum adjustment		.01	08/12/2014	100,951	08/12/2014	8,918	3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		100,951		8,918	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				84,054,376		22,919,411	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		3,769,655		528,979	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				87,824,031		23,448,390	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other)** **[ ] IPF [ ] SNF** **[XX] IRF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				11,942,027		2,903	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				11,942,027		2,903	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		372,540		30	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				12,314,567		2,933	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] 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 (Wkst. S-3, Pt. I, col. 15, line 14)	20,221	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	46,737	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	7,877	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	86,628	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	1,912,060,830	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	53,478,200	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	2,828,415	8
9	Sequestration adjustment amount (see instructions)	56,568	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	2,771,847	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	2,706,092	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	65,755	32

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)		1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	21.279452	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)		16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)		18
19	Deductibles		19
20	Subtotal (line 18 minus line 19)		20
21	Coinsurance		21
22	Subtotal (line 20 minus line 21)		22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)		26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)		31
31.01	Sequestration adjustment (see instructions)		31.01
32	Interim payments		32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	12,049,170		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.012900		2
3	Inpatient Rehabilitation LIP payments (see instructions)	237,369		3
4	Outlier payments	77,910		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	30.928767		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	12,364,449		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	12,364,449		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	12,364,449		19
20	Deductibles	46,208		20
21	Subtotal (line 19 minus line 20)	12,318,241		21
22	Coinsurance	30,400		22
23	Subtotal (line 21 minus line 22)	12,287,841		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	304		24
25	Adjusted reimbursable bad debts (see instructions)	198		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)			26
27	Subtotal (sum of lines 23 and 25)	12,288,039		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)	26,528		29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	12,314,567		32
32.01	Sequestration adjustment (see instructions)	246,291		32.01
33	Interim payments	11,942,027		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	126,249		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	16,261		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	77,910		50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	18,585,152		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	18,585,152		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	18,585,152		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	18,585,152		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	18,585,152		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

Check Applicable Boxes: [ ] Title V [XX] Title XIX [ ] Hospital [XX] Subprovider IPF [ ] SNF [ ] NF [ ] ICF/MR [XX] PPS [ ] TEFRA [ ] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

Check Applicable Boxes: [ ] Title V [XX] Title XIX [ ] Hospital [XX] Subprovider IRF [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	209,825		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	209,825		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	209,825		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	209,825		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			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	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	209,825		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

Check Applicable Box:
[ ] Title V
[XX] Title XVIII
[ ] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			9.00	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			5.85	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			5.85	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			9.00	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			1.00	6
7	Enter the lesser of line 5 or line 6			1.00	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	1.00	0.00	1.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	1.00	0.00	1.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	1.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.44	0.37		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.96	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.80	0.12		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.80	0.12		17
18	Per resident amount	114,941.00	114,941.00		18
19	Approved amount for resident costs	91,953	13,793	105,746	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			105,746	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	55,298	8,474		26
27	Total inpatient days (see instructions)	105,684	105,684		27
28	Ratio of inpatient days to total inpatient days	0.523239	0.080182		28
29	Program direct GME amount	55,330	8,479		29
30	Reduction for direct GME payments for Medicare Advantage		1,198		30
31	Net Program direct GME amount			62,611	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			113,421,680	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			14,917	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			113,406,763	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			29,330,257	42
43	Primary payer payments (see instructions)			11,687	43
44	Total Part B reasonable cost (line 42 minus line 43)			29,318,570	44
45	Total reasonable cost (sum of lines 41 and 44)			142,725,333	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.794580	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.205420	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			62,611	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			49,749	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			12,862	50

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

Check Applicable Box:
[ ] Title V
[ ] Title XVIII
[XX] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	17,230	759		26
27	Total inpatient days (see instructions)	105,684	105,684		27
28	Ratio of inpatient days to total inpatient days	0.163033	0.007182		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	13,454,000				1
2	Temporary investments	1,539,000				2
3	Notes receivable	71,000				3
4	Accounts receivable	75,992,000				4
5	Other receivables	5,508,000				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	8,851,000				7
8	Prepaid expenses					8
9	Other current assets	-249,000				9
10	Due from other funds	5,055,000				10
11	Total current assets (sum of lines 1-10)	110,221,000				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	219,548,000				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	219,548,000				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,055,000				34
35	Total other assets (sum of lines 31-34)	5,055,000				35
36	Total assets (sum of lines 11, 30 and 35)	334,824,000				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	25,343,000				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	874,000				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	2,030,000				43
44	Other current liabilities	56,759,000				44
45	Total current liabilities (sum of lines 37 thru 44)	85,006,000				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	4,487,000				49
50	Total long term liabilities (sum of lines 46 thru 49)	4,487,000				50
51	Total liabilities (sum of lines 45 and 50)	89,493,000				51
	CAPITAL ACCOUNTS					
52	General fund balance	245,331,000				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	245,331,000				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	334,824,000				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		259,820,135			1
2	Net income (loss) (from Worksheet G-3, line 29)		10,008,413			2
3	Total (sum of line 1 and line 2)		269,828,548			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		269,828,548			11
12	Deductions (debit adjustments) (specify)					12
13	ASSETS RELEASED FROM RESTRICTIONS	24,497,548				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		24,497,548			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		245,331,000			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	ASSETS RELEASED FROM RESTRICTIONS					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)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	180,462,495		180,462,495	1
2	Subprovider IPF				2
3	Subprovider IRF	20,467,294		20,467,294	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)	200,929,789		200,929,789	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	43,120,374		43,120,374	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit	31,129,190		31,129,190	14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	74,249,564		74,249,564	16
17	Total inpatient routine care services (sum of lines 10 and 16)	275,179,353		275,179,353	17
18	Ancillary services	798,619,204	838,287,958	1,636,907,162	18
19	Outpatient services		11,667,883	11,667,883	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (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 column 3 to Worksheet G-3, line 1)	1,073,798,557	849,955,841	1,923,754,398	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		374,405,501	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 Worksheet G-3, line 4)		374,405,501	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,923,754,398	1
2	Less contractual allowances and discounts on patients' accounts	1,547,793,308	2
3	Net patient revenues (line 1 minus line 2)	375,961,090	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	374,405,501	4
5	Net income from service to patients (line 3 minus line 4)	1,555,589	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr 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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (ALL OTHER)	8,251,583	24
24.01	Other (OTHER GAINS)	201,241	24.01
25	Total other income (sum of lines 6-24)	8,452,824	25
26	Total (line 5 plus line 25)	10,008,413	26
29	Net income (or loss) for the period (line 26 minus line 28)	10,008,413	29

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0007** **WORKSHEET L**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[XX] PPS** **[ ] Cost Method**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	6,433,918	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	276,875	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	237.34	3
4	Number of interns & residents (see instructions)	0.99	4
5	Indirect medical education percentage (see instructions)	0.12	5
6	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	7,721	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0397	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.2233	8
9	Sum of lines 7 and 8	0.2630	9
10	Allowable disproportionate share percentage (see instructions)	0.0547	10
11	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	351,935	11
12	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	7,070,449	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
34	Surgical Intensive Care Unit							34
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY							76
76.10	OUTPATIENT PSYCH							76.10
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 Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC							192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	48.92		18.32				67.24	30
31	Intensive Care Unit	40.95		13.79				54.74	31
34	Surgical Intensive Care Unit	45.05		9.94				54.99	34
43	Nursery			64.40				64.40	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	18.72	14.84					33.56	50
54	Radiology-Diagnostic	18.83	14.98					33.81	54
60	Laboratory	26.27	6.73					33.00	60
65	Respiratory Therapy	47.98	2.18					50.16	65
66	Physical Therapy	15.86	5.42					21.28	66
69	Electrocardiology	25.29	22.17					47.46	69
70	Electroencephalography	15.13	17.10					32.23	70
71	Medical Supplies Charged to Pat	29.09	11.96					41.05	71
72	Impl. Dev. Charged to Patients	31.40	12.28					43.68	72
73	Drugs Charged to Patients	39.13	6.73					45.86	73
76	OTHER ANCILLARY	4.65	26.76					31.41	76
76.10	OUTPATIENT PSYCH	10.37	0.04					10.41	76.10
76.97	CARDIAC REHABILITATION	0.24	49.87					50.11	76.97
91	Emergency	17.31	10.80					28.11	91
92	Observation Beds (Non-Distinct	16.79	26.24					43.03	92
200	TOTAL CHARGES	24.20	12.38					36.58	200

REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IRF

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
41	Subprovider - IRF	75.83		2.70				78.53	41
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	0.04						0.04	50
54	Radiology-Diagnostic	0.33	0.01					0.34	54
60	Laboratory	1.33						1.33	60
65	Respiratory Therapy	1.99						1.99	65
66	Physical Therapy	19.90						19.90	66
69	Electrocardiology	0.30						0.30	69
70	Electroencephalography	0.47						0.47	70
71	Medical Supplies Charged to Pat	0.72	0.01					0.73	71
73	Drugs Charged to Patients	2.46						2.46	73
91	Emergency	0.02						0.02	91
200	TOTAL CHARGES	1.40						1.40	200

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	24,249,750	6.78	-24,249,750	-13.04			1
2	Cap Rel Costs-Mvble Equip	6,616,061	1.85	-6,616,061	-3.56			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	27,141,082	7.59	-27,141,082	-14.60			4
5	Administrative & General	73,325,302	20.49	-73,325,302	-39.44			5
6	Maintenance & Repairs							6
7	Operation of Plant	13,649,407	3.81	-13,649,407	-7.34			7
8	Laundry & Linen Service	982,957	0.27	-982,957	-0.53			8
9	Housekeeping	3,817,862	1.07	-3,817,862	-2.05			9
10	Dietary	875,650	0.24	-875,650	-0.47			10
11	Cafeteria	3,521,065	0.98	-3,521,065	-1.89			11
12	Maintenance of Personnel							12
13	Nursing Administration	5,867,008	1.64	-5,867,008	-3.16			13
14	Central Services & Supply	1,649,524	0.46	-1,649,524	-0.89			14
15	Pharmacy	19,250,710	5.38	-19,250,710	-10.35			15
16	Medical Records & Library	4,243,328	1.19	-4,243,328	-2.28			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	76,811	0.02	-76,811	-0.04			22
23	PARAMED ED PRGM-(SPECIFY)	649,363	0.18	-649,363	-0.35			23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	29,323,531	8.20	45,733,981	24.60	75,057,512	20.98	30
31	Intensive Care Unit	6,401,430	1.79	7,493,746	4.03	13,895,176	3.88	31
34	Surgical Intensive Care Unit	4,240,430	1.19	5,422,190	2.92	9,662,620	2.70	34
40	Subprovider - IPF	3,072,995	0.86	4,833,337	2.60	7,906,332	2.21	40
41	Subprovider - IRF	3,303,033	0.92	4,463,261	2.40	7,766,294	2.17	41
43	Nursery	1,336,034	0.37	1,715,910	0.92	3,051,944	0.85	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,119,059	4.23	16,870,141	9.07	31,989,200	8.94	50
54	Radiology-Diagnostic	11,104,923	3.10	12,163,297	6.54	23,268,220	6.50	54
60	Laboratory	13,602,969	3.80	6,116,835	3.29	19,719,804	5.51	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,617,197	0.73	1,945,249	1.05	4,562,446	1.28	65
66	Physical Therapy	9,462,740	2.64	6,181,862	3.33	15,644,602	4.37	66
69	Electrocardiology	3,284,072	0.92	4,257,822	2.29	7,541,894	2.11	69
70	Electroencephalography	347,266	0.10	617,606	0.33	964,872	0.27	70
71	Medical Supplies Charged to Patients	16,213,262	4.53	7,188,378	3.87	23,401,640	6.54	71
72	Impl. Dev. Charged to Patients	24,488,644	6.84	10,436,375	5.61	34,925,019	9.76	72
73	Drugs Charged to Patients			28,186,362	15.16	28,186,362	7.88	73
76	OTHER ANCILLARY	6,053,310	1.69	4,924,703	2.65	10,978,013	3.07	76
76.10	OUTPATIENT PSYCH	354,541	0.10	304,159	0.16	658,700	0.18	76.10
76.97	CARDIAC REHABILITATION	499,356	0.14	796,118	0.43	1,295,474	0.36	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
91	Emergency	8,128,804	2.27	9,069,784	4.88	17,198,588	4.81	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192.01	OTHER NRCC	12,917,405	3.61	7,194,764	3.87	20,112,169	5.62	192.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	357,786,881	100.00			357,786,881	100.00	202

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,988,446	169,605,601	0.023516	31,756,384	746,783	50
54	Radiology-Diagnostic	2,704,972	364,989,458	0.007411	68,712,379	509,227	54
60	Laboratory	874,814	252,365,088	0.003466	66,293,656	229,774	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	206,538	40,923,359	0.005047	19,633,894	99,092	65
66	Physical Therapy	679,807	61,254,487	0.011098	9,712,751	107,792	66
69	Electrocardiology	1,017,196	120,700,458	0.008427	30,521,357	257,203	69
70	Electroencephalography	180,432	5,283,185	0.034152	799,246	27,296	70
71	Medical Supplies Charged to Pat	828,640	141,078,308	0.005874	41,036,557	241,049	71
72	Impl. Dev. Charged to Patients	1,222,129	104,805,148	0.011661	32,908,424	383,745	72
73	Drugs Charged to Patients	710,669	159,883,985	0.004445	62,560,107	278,080	73
76	OTHER ANCILLARY	417,638	36,474,796	0.011450	1,697,033	19,431	76
76.10	OUTPATIENT PSYCH	28,482	1,314,333	0.021670	136,264	2,953	76.10
76.97	CARDIAC REHABILITATION	220,702	2,165,181	0.101932	5,297	540	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	1,555,034	152,722,386	0.010182	26,440,247	269,215	91
92	Observation Beds (Non-Distinct	1,318,270	23,663,327	0.055709	3,973,363	221,352	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	15,953,769	1,637,229,100		396,186,959	3,393,532	200

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	10,142,364		10,142,364	82,699	122.64	40,458	4,961,769	30
31	Intensive Care Unit	1,333,394		1,333,394	8,139	163.83	3,333	546,045	31
34	Surgical Intensive Care Unit	1,018,477		1,018,477	6,539	155.75	2,946	458,840	34
200	TOTAL	12,494,235		12,494,235	97,377		46,737	5,966,654	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	5,966,654
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	3,393,532
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	9,360,186
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	9,616
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	46,737
PER DISCHARGE CAPITAL COSTS	973.40

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	93,301,592
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	513,217,100
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.182

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	
3. RATIO OF COST TO CHARGES (line 1 / line 2)	

COST TO CHARGE RATIO FOR REHAB SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 41 + Worksheet D, Part IV, column 11, line 200))	10,310,843
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 41, column 2 plus Worksheet D-3, line 202, column 2)	38,688,979
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.267

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	9,360,186
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.018

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01 & 2.02 x (Worksheet B, Part I, column 26 - columns 20 & 23 / Worksheet C, Part I, column 8) less lines 61, 66-68, 74, 94, 95 & 96) (see CR 5999)	28,392,080
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	199,360,209
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.142