ST. BERNARD HOSPITAL Provider CCN: 14-0103	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/28/2015 Run Time: 09:33 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. [ ] 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 ST. BERNARD HOSPITAL (14-0103) {(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		-3,180,032	29,487	-121,318		1
2	SUBPROVIDER - IPF		-24,060				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-3,204,092	29,487	-121,318		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: 64TH & DAN RYAN	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60621 County: COOK	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	ST. BERNARD HOSPITAL	14-0103	16974	1	07 / 01 / 1967	N	P	P	3
4	Subprovider - IPF	ST. BERNARD HOSPITAL PSYCH UNIT	14-S103	16974	4	01 / 01 / 1994	N	P	P	4
5	Subprovider - IRF									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.	9,620	10	86		7,963	15	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.							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)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, 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.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 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)				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.		N	N	N	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.				118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:				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)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are 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.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	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			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (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)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public 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		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.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y		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)	Y	05/11/2015	Y	05/11/2015	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)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	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: JANE	Last name: BACHMANN	Title: CONSULTANT	41
42	Employer: BACHMANN ASSOCIATES			42
43	Phone number: 3122852828	E-mail Address: JBOPIL@ATT.NET		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	148	54,020			6,042	6,415	21,602	1
2	HMO and other (see instructions)						1,247	8,665		2
3	HMO IPF Subprovider							3,347		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)		148	54,020			6,042	6,415	21,602	7
8	Intensive Care Unit	31	10	3,650			1,225	926	3,315	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						1,673	2,803	13
14	Total (see instructions)		158	57,670			7,267	9,014	27,720	14
15	CAH Visits									15
16	Subprovider - IPF	40	40	14,600			2,698	4,841	11,836	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		198							27
28	Observation Bed Days								1,276	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							15	55	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)					1,338	1,870	5,917	1
2	HMO and other (see instructions)					230	2,069		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)	4.01	717.59			1,338	1,870	5,917	14
15	CAH Visits								15
16	Subprovider - IPF		44.22			327	663	1,595	16
17	Subprovider - IRF								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)	4.01	761.81						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	42,592,451		42,592,451	1,590,654.00	26.78	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		200,532		200,532	2,088.00	96.04	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)		411,681		411,681	8,373.00	49.17	7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		2,919,067	655,626	3,574,693	139,732.00	25.58	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		2,357,806		2,357,806	63,229.00	37.29	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		25,650		25,650	202.00	126.98	13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		9,864,884		9,864,884			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		945,924		945,924			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		24,733		24,733			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		234,249		234,249	9,250.00	25.32	26
27	Administrative & General		5,803,145	-101,659	5,701,486	186,410.00	30.59	27
28	Administrative & General under contract (see instructions)		343,840		343,840	1,011.45	339.95	28
29	Maintenance & Repairs							29
30	Operation of Plant		2,177,559		2,177,559	101,602.00	21.43	30
31	Laundry & Linen Service		87,710		87,710	6,348.00	13.82	31
32	Housekeeping		1,368,301		1,368,301	110,497.00	12.38	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		841,482	-422,738	418,744	34,239.00	12.23	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			391,125	391,125	31,604.00	12.38	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,056,422		1,056,422	27,353.00	38.62	38
39	Central Services and Supply		332,513		332,513	21,298.00	15.61	39
40	Pharmacy		1,299,472		1,299,472	42,345.00	30.69	40
41	Medical Records & Medical Records Library		550,708		550,708	30,172.00	18.25	41
42	Social Service		1,068,054	-286,888	781,166	23,637.00	33.05	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		42,324,078		42,324,078	1,581,204.45	26.77	1
2	Excluded area salaries (see instructions)		2,919,067	655,626	3,574,693	139,732.00	25.58	2
3	Subtotal salarles (line 1 minus line 2)		39,405,011	-655,626	38,749,385	1,441,472.45	26.88	3
4	Subtotal other wages & related costs (see instructions)		2,383,456		2,383,456	63,431.00	37.58	4
5	Subtotal wage-related costs (see instructions)		9,864,884		9,864,884		25.46%	5
6	Total (sum of lines 3 through 5)		51,653,351	-655,626	50,997,725	1,504,903.45	33.89	6
7	Total overhead cost (see instructions)		15,163,455	-420,160	14,743,295	625,766.45	23.56	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
3	Nonqualified Defined Benefit Plan Cost (see instructions)	800,889	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	6,202,708	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	66,027	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	116,271	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	442,055	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	3,128,388	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	72,000	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	7,203	23
24	Total Wage Related cost (Sum of lines 1-23)	10,835,541	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	09/30/2016		1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)	01/01/2012	12/31/2012	2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month	7/01/2012		3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)	1/01/2011		4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)	1/01/2014		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	01/01/2012		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	1/01/2011		9
10	Ending Date of Averaging Period from Line 5	1/01/2014		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)	36		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	12		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	2,357,806	10,835,541	1
2	Hospital	2,357,806	10,835,541	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)	0.425926	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	25,523,956	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	2,500,000	5
6	Medicaid charges	113,178,776	6
7	Medicaid cost (line 1 times line 6)	48,205,783	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.	20,181,827	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)	20,181,827	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	11,450,847		11,450,847	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	4,877,213		4,877,213	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	4,877,213		4,877,213	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?		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)	-1,340,570	26
27	Medicare bad debts for the entire hospital complex (see instructions)	502,362	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	-1,842,932	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	-784,953	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	4,092,260	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	24,274,087	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		4,083,349	4,083,349	-2,195,995	1,887,354		1,887,354	1
2	00200	Cap Rel Costs-Mvble Equip				2,838,521	2,838,521	-1,653	2,836,868	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	234,249	7,649,258	7,883,507	-3,099	7,880,408		7,880,408	4
5	00500	Administrative & General	5,803,145	12,346,955	18,150,100	-176,991	17,973,109	-7,569,354	10,403,755	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	2,177,559	3,208,446	5,386,005	-123,221	5,262,784	-73,375	5,189,409	7
8	00800	Laundry & Linen Service	87,710	380,976	468,686		468,686		468,686	8
9	00900	Housekeeping	1,368,301	561,106	1,929,407		1,929,407		1,929,407	9
10	01000	Dietary	841,482	1,935,767	2,777,249	-1,327,322	1,449,927	-498,004	951,923	10
11	01100	Cafeteria		746	746	1,290,879	1,291,625		1,291,625	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,056,422	252,092	1,308,514	-393	1,308,121		1,308,121	13
14	01400	Central Services & Supply	332,513	660,689	993,202	-375,675	617,527		617,527	14
15	01500	Pharmacy	1,299,472	1,689,324	2,988,796	-1,537,122	1,451,674		1,451,674	15
16	01600	Medical Records & Library	550,708	534,015	1,084,723	-8,012	1,076,711	-59,863	1,016,848	16
17	01700	Social Service	1,068,054	387,296	1,455,350	-286,888	1,168,462		1,168,462	17
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd				411,681	411,681		411,681	22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	11,345,231	4,276,405	15,621,636	-3,740,662	11,880,974	-1,719,190	10,161,784	30
31	03100	Intensive Care Unit	2,288,196	494,625	2,782,821	-273,560	2,509,261		2,509,261	31
40	04000	Subprovider - IPF	2,404,183	548,792	2,952,975	575,364	3,528,339	-316,147	3,212,192	40
43	04300	Nursery	1,611	404,484	406,095	1,672,686	2,078,781	-264,915	1,813,866	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,340,125	809,856	2,149,981	-567,700	1,582,281		1,582,281	50
52	05200	Delivery Room & Labor Room	2,239	134,941	137,180	1,286,144	1,423,324		1,423,324	52
53	05300	Anesthesiology	21,291	1,840,270	1,861,561	-80,264	1,781,297	-1,719,985	61,312	53
54	05400	Radiology-Diagnostic	2,203,528	1,023,463	3,226,991	-77,429	3,149,562		3,149,562	54
60	06000	Laboratory	2,262,800	2,763,739	5,026,539	-132,283	4,894,256	-206,752	4,687,504	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy		1,727,783	1,727,783	142,388	1,870,171		1,870,171	65
66	06600	Physical Therapy	345,791	63,178	408,969		408,969		408,969	66
69	06900	Electrocardiology		149,457	149,457	-149,457				69
71	07100	Medical Supplies Charged to Patients				2,201,628	2,201,628		2,201,628	71
72	07200	Impl. Dev. Charged to Patients				217,111	217,111		217,111	72
73	07300	Drugs Charged to Patients				1,504,298	1,504,298		1,504,298	73
74	07400	Renal Dialysis		281,103	281,103	-653	280,450		280,450	74
76.97	07697	CARDIAC REHABILITATION								76.97
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	764,688	1,230,566	1,995,254	-2,212	1,993,042	-1,189,504	803,538	90
91	09100	Emergency	4,278,269	4,980,908	9,259,177	-1,182,267	8,076,910	-3,557,477	4,519,433	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		43,797	43,797	-43,797				113
118		SUBTOTALS (sum of lines 1-117)	42,077,567	54,463,386	96,540,953	-144,302	96,396,651	-17,176,219	79,220,432	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	278,962	213,810	492,772		492,772		492,772	192
194	07950	OUTPATIENT PHARMACY	235,922	704,407	940,329	-2,296	938,033		938,033	194
194.01	07951	PUBLIC RELATIONS				146,598	146,598		146,598	194.01
200		TOTAL (sum of lines 118-199)	42,592,451	55,381,603	97,974,054		97,974,054	-17,176,219	80,797,835	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASSIFY POST PARTUM	A	Nursery	43	1,564,925	199,481	1
2			Delivery Room & Labor Room	52	1,237,306	157,719	2
500	Total reclassifications				2,802,231	357,200	500
	Code Letter - A						
1	RECLASSIFY INTERNS & RESIDENTS	B	I&R Services-Other Prgm Costs	22		411,681	1
500	Total reclassifications					411,681	500
	Code Letter - B						
1	RECLASSIFY MEDICAL SUPPLIES	C	Medical Supplies Charged to P	71		178,233	1
500	Total reclassifications					178,233	500
	Code Letter - C						
1	RECLASSIFY DRUGS SOLD	D	Drugs Charged to Patients	73		1,504,298	1
2			Medical Supplies Charged to P	71		32,824	2
500	Total reclassifications					1,537,122	500
	Code Letter - D						
1	RECLASSIFY DIETARY COSTS	E	Subprovider - IPF	40	31,613	2,371	1
500	Total reclassifications				31,613	2,371	500
	Code Letter - E						
1	RECLASSIFY SOCIAL SERVICE	F	Emergency	91	34,795		1
2			Subprovider - IPF	40	252,093		2
500	Total reclassifications				286,888		500
	Code Letter - F						
1	RECLASSIFY EMERGENCY ROOM	G	Subprovider - IPF	40	270,261	20,270	1
500	Total reclassifications				270,261	20,270	500
	Code Letter - G						
1	RECLASSIFY DEPRECIATION	H	Cap Rel Costs-Mvble Equip	2		2,294,549	1
500	Total reclassifications					2,294,549	500
	Code Letter - H						
1	RECLASSIFY PROPERTY INSURANCE	I	Cap Rel Costs-Bldg & Fixt	1		98,554	1
500	Total reclassifications					98,554	500
	Code Letter - I						
1	RECLASSIFY INTEREST EXPENSE	J	Cap Rel Costs-Mvble Equip	2		43,797	1
500	Total reclassifications					43,797	500
	Code Letter - J						
1	RECLASSIFY EQUIPMENT RENTAL	K	Cap Rel Costs-Mvble Equip	2		500,175	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
500	Total reclassifications					500,175	500
	Code Letter - K						
1	RECLASSIFY CAFETERIA COSTS	L	Cafeteria	11	391,125	899,754	1
500	Total reclassifications				391,125	899,754	500
	Code Letter - L						
1	RECLASS EKG COSTS	M	Respiratory Therapy	65		149,457	1
500	Total reclassifications					149,457	500
	Code Letter - M						
1	RECLASS MEDICAL SUPPLIES EXP	O	Medical Supplies Charged to P	71		2,207,682	1
2							2
3							3
4							4
5							5

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
6							6
7							7
8							8
500	Total reclassifications					2,207,682	500
	Code Letter - O						
1	RECLASS PR COSTS	P	PUBLIC RELATIONS	194.01	101,659	44,939	1
500	Total reclassifications				101,659	44,939	500
	Code Letter - P						
1	RECLASS IMPLANT COSTS	Q	Impl. Dev. Charged to Patient	72		217,111	1
500	Total reclassifications					217,111	500
	Code Letter - Q						
	GRAND TOTAL (Increases)				3,883,777	8,962,895	

(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.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RECLASSIFY POST PARTUM	A	Adults & Pediatrics	30	1,564,925	199,481		1
2			Adults & Pediatrics	30	1,237,306	157,719		2
500	Total reclassifications				2,802,231	357,200		500
	Code letter - A							
1	RECLASSIFY INTERNS & RESIDENTS	B	Emergency	91		411,681		1
500	Total reclassifications					411,681		500
	Code letter - B							
1	RECLASSIFY MEDICAL SUPPLIES	C	Central Services & Supply	14		178,233		1
500	Total reclassifications					178,233		500
	Code letter - C							
1	RECLASSIFY DRUGS SOLD	D	Pharmacy	15		1,504,298		1
2			Pharmacy	15		32,824		2
500	Total reclassifications					1,537,122		500
	Code letter - D							
1	RECLASSIFY DIETARY COSTS	E	Dietary	10	31,613	2,371		1
500	Total reclassifications				31,613	2,371		500
	Code letter - E							
1	RECLASSIFY SOCIAL SERVICE	F	Social Service	17	34,795			1
2			Social Service	17	252,093			2
500	Total reclassifications				286,888			500
	Code letter - F							
1	RECLASSIFY EMERGENCY ROOM	G	Emergency	91	270,261	20,270		1
500	Total reclassifications				270,261	20,270		500
	Code letter - G							
1	RECLASSIFY DEPRECIATION	H	Cap Rel Costs-Bldg & Fixt	1		2,294,549	9	1
500	Total reclassifications					2,294,549		500
	Code letter - H							
1	RECLASSIFY PROPERTY INSURANCE	I	Operation of Plant	7		98,554	12	1
500	Total reclassifications					98,554		500
	Code letter - I							
1	RECLASSIFY INTEREST EXPENSE	J	Interest Expense	113		43,797	11	1
500	Total reclassifications					43,797		500
	Code letter - J							
1	RECLASSIFY EQUIPMENT RENTAL	K	Administrative & General	5		30,393	10	1
2			Employee Benefits Department	4		3,099		2
3			Operation of Plant	7		24,667		3
4			Dietary	10		2,459		4
5			Nursing Administration	13		393		5
6			Adults & Pediatrics	30		10,038		6
7			OUTPATIENT PHARMACY	194		2,296		7
8			Central Services & Supply	14		197,442		8
9			Medical Records & Library	16		8,012		9
10			Renal Dialysis	74		653		10
11			Delivery Room & Labor Room	52		887		11
12			Subprovider - IPF	40		1,244		12
13			Operating Room	50		2,939		13
14			Clinic	90		2,212		14
15			Radiology-Diagnostic	54		77,429		15
16			Laboratory	60		132,283		16
17			Emergency	91		3,729		17
500	Total reclassifications					500,175		500
	Code letter - K							
1	RECLASSIFY CAFETERIA COSTS	L	Dietary	10	391,125	899,754		1
500	Total reclassifications				391,125	899,754		500
	Code letter - L							
1	RECLASS EKG COSTS	M	Electrocardiology	69		149,457		1
500	Total reclassifications					149,457		500
	Code letter - M							
1	RECLASS MEDICAL SUPPLIES EXP	O	Adults & Pediatrics	30		571,193		1
2			Intensive Care Unit	31		273,560		2
3			Nursery	43		91,720		3
4			Operating Room	50		564,761		4

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	
5			Anesthesiology	53		80,264		5
6			Respiratory Therapy	65		7,069		6
7			Emergency	91		511,121		7
8			Delivery Room & Labor Room	52		107,994		8
500	Total reclassifications					2,207,682		500
	Code letter - O							
1	RECLASS PR COSTS	P	Administrative & General	5	101,659	44,939		1
500	Total reclassifications				101,659	44,939		500
	Code letter - P							
1	RECLASS IMPLANT COSTS	Q	Medical Supplies Charged to P	71		217,111		1
500	Total reclassifications					217,111		500
	Code letter - Q							
	GRAND TOTAL (Decreases)				3,883,777	8,962,895		

(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	2,192,754					2,192,754		1
2	Land Improvements	3,283,156	74,066		74,066		3,357,222		2
3	Buildings and Fixtures	44,593,210	5,442,099		5,442,099		50,035,309		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	40,938,834	3,499,523		3,499,523	97,007	44,341,350		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	91,007,954	9,015,688		9,015,688	97,007	99,926,635		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	91,007,954	9,015,688		9,015,688	97,007	99,926,635		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	4,083,349						4,083,349	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	4,083,349						4,083,349	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	55,585,285		55,585,285	0.556261					1
2	Cap Rel Costs-Mvble Equ	44,341,350		44,341,350	0.443739					2
3	Total (sum of lines 1-2)	99,926,635		99,926,635	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	1,788,800			98,554			1,887,354	1
2	Cap Rel Costs-Mvble Equip	2,294,549	500,175	42,144				2,836,868	2
3	Total (sum of lines 1-2)	4,083,349	500,175	42,144	98,554			4,724,222	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)	B	-1,653	Cap Rel Costs-Mvble Equip	2	11	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	-7,836,792				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-498,004	Dietary	10		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	B	-59,863	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-15,543	Operation of Plant	7		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	SISTERS MAINTENANCE	B	-12,000	Administrative & General	5		33
34	DISCOUNTS	B	-1,337	Administrative & General	5		34
35	OFFSET PEDS MOBILE VAN EXPENSES	A	-259,413	Clinic	90		35
36							36
37							37
38	MISCELLANEOUS REVENUE	B	-133,721	Administrative & General	5		38
39	EMPLOYEE ROOM RENTALS	B	-57,832	Operation of Plant	7		39
40	ANESTHESIOLOGIST BILLING EXPENSE	A	-32,282	Anesthesiology	53		40
41	ER PHYSICIAN BILLING EXPENSE	A	-283,845	Emergency	91		41
42	OFFSET DENTAL CLINIC COSTS	A	-566,513	Clinic	90		42
43	OFFSET OTHER LOBBYING COSTS	A	-265,000	Administrative & General	5		43
44							44
45	OFFSET PROVIDER TAX	A	-7,152,421	Administrative & General	5		45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-17,176,219				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
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							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							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	30	Adults & Pediatrics AGGREGATE	1,719,190	1,719,190						1
2	43	Nursery AGGREGATE	264,915	264,915						2
3	53	Anesthesiology AGGREGATE	1,687,703	1,687,703						3
4	60	Laboratory AGGREGATE	206,752	206,752						4
5	91	Emergency AGGREGATE	3,273,632	3,273,632						5
6	90	Clinic AGGREGATE	363,578	363,578						6
7	5	Administrative & Gen	24,000		24,000	221,000	180	19,125	956	7
8	40	Subprovider - IPF AGGREGATE	316,147	316,147						8
9	5	Administrative & Gen	1,650		1,650	221,000	22	2,338	117	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	7,857,567	7,831,917	25,650		202	21,463	1,073	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	30	Adults & Pediatrics AGGREGATE							1,719,190	1
2	43	Nursery AGGREGATE							264,915	2
3	53	Anesthesiology AGGREGATE							1,687,703	3
4	60	Laboratory AGGREGATE							206,752	4
5	91	Emergency AGGREGATE							3,273,632	5
6	90	Clinic AGGREGATE							363,578	6
7	5	Administrative & Gen					19,125	4,875	4,875	7
8	40	Subprovider - IPF AGGREGATE							316,147	8
9	5	Administrative & Gen					2,338			9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					21,463	4,875	7,836,792	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	1,887,354	1,887,354					1
2	Cap Rel Costs-Mvble Equip	2,836,868		2,836,868				2
4	Employee Benefits Department	7,880,408	4,573	6,873	7,891,854			4
5	Administrative & General	10,403,755	621,453	934,105	1,062,255	13,021,568	13,021,568	5
6	Maintenance & Repairs							6
7	Operation of Plant	5,189,409	263,983	396,790	405,705	6,255,887	1,201,919	7
8	Laundry & Linen Service	468,686	10,334	15,532	16,341	510,893	98,156	8
9	Housekeeping	1,929,407	24,178	36,341	254,931	2,244,857	431,295	9
10	Dietary	951,923	31,643	47,562	78,017	1,109,145	213,096	10
11	Cafeteria	1,291,625	13,472	20,250	72,871	1,398,218	268,634	11
12	Maintenance of Personnel							12
13	Nursing Administration	1,308,121	22,956	34,505	196,824	1,562,406	300,179	13
14	Central Services & Supply	617,527	15,438	23,204	61,951	718,120	137,970	14
15	Pharmacy	1,451,674	12,893	19,379	242,107	1,726,053	331,620	15
16	Medical Records & Library	1,016,848	47,872	71,956	102,604	1,239,280	238,098	16
17	Social Service	1,168,462	7,460	11,214	145,541	1,332,677	256,042	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	411,681				411,681	79,095	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,161,784	205,318	308,612	1,591,677	12,267,391	2,356,868	30
31	Intensive Care Unit	2,509,261	38,746	58,239	426,318	3,032,564	582,634	31
40	Subprovider - IPF	3,212,192	79,848	120,019	551,139	3,963,198	761,433	40
43	Nursery	1,813,866	10,469	15,735	291,864	2,131,934	409,600	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,582,281	76,193	114,525	249,681	2,022,680	388,609	50
52	Delivery Room & Labor Room	1,423,324	31,194	46,887	230,942	1,732,347	332,829	52
53	Anesthesiology	61,312	2,694	4,050	3,967	72,023	13,837	53
54	Radiology-Diagnostic	3,149,562	39,446	59,291	410,544	3,658,843	702,959	54
60	Laboratory	4,687,504	46,361	69,685	421,587	5,225,137	1,003,885	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,870,171	32,174	48,360		1,950,705	374,781	65
66	Physical Therapy	408,969	14,013	21,063	64,425	508,470	97,690	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	2,201,628				2,201,628	422,990	71
72	Impl. Dev. Charged to Patients	217,111				217,111	41,713	72
73	Drugs Charged to Patients	1,504,298				1,504,298	289,015	73
74	Renal Dialysis	280,450				280,450	53,882	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	803,538	18,484	27,784	142,471	992,277	190,642	90
91	Emergency	4,519,433	66,757	100,343	753,223	5,439,756	1,045,119	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)	79,220,432	1,737,952	2,612,304	7,776,985	78,731,597	12,624,590	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	492,772	144,515	217,219	51,974	906,480	174,158	192
194	OUTPATIENT PHARMACY	938,033	4,887	7,345	43,955	994,220	191,016	194
194.01	PUBLIC RELATIONS	146,598			18,940	165,538	31,804	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	80,797,835	1,887,354	2,836,868	7,891,854	80,797,835	13,021,568	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	7,457,806						7
8	Laundry & Linen Service	77,271	686,320					8
9	Housekeeping	180,792		2,856,944				9
10	Dietary	236,614		93,891	1,652,746			10
11	Cafeteria	100,741		39,975		1,807,568		11
12	Maintenance of Personnel							12
13	Nursing Administration	171,656		68,115		44,859	2,147,215	13
14	Central Services & Supply	115,437		45,807		34,928		14
15	Pharmacy	96,408		38,256		69,445		15
16	Medical Records & Library	357,972		142,048		49,482		16
17	Social Service	55,786		22,137		38,763		17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,535,301	374,807	609,226	936,309	501,973	845,866	30
31	Intensive Care Unit	289,729	57,517	114,968	119,440	99,854	168,261	31
40	Subprovider - IPF	597,078	205,362	236,928	596,997	194,571	327,876	40
43	Nursery	78,282	48,634	31,063		80,609	135,834	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	569,744		226,081		71,363	120,253	50
52	Delivery Room & Labor Room	233,256		92,559		63,727	107,386	52
53	Anesthesiology	20,148		7,995		2,842		53
54	Radiology-Diagnostic	294,964		117,045		129,166		54
60	Laboratory	346,671		137,563		127,556		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	240,586		95,467				65
66	Physical Therapy	104,785		41,580		15,683		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	138,221		54,848		58,316	98,269	90
91	Emergency	499,190		198,084		203,816	343,470	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)	6,340,632	686,320	2,413,636	1,652,746	1,786,953	2,147,215	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,080,633		428,808				192
194	OUTPATIENT PHARMACY	36,541		14,500		13,766		194
194.01	PUBLIC RELATIONS					6,849		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,457,806	686,320	2,856,944	1,652,746	1,807,568	2,147,215	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	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	1,052,262						14
15	Pharmacy		2,261,782					15
16	Medical Records & Library			2,026,880				16
17	Social Service				1,705,405			17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					490,776		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	225,026	51,978	372,962	931,341		21,009,048	30
31	Intensive Care Unit	108,174	15,494	77,648	142,922		4,809,205	31
40	Subprovider - IPF	8,797	5,115	143,879	510,294		7,551,528	40
43	Nursery	36,269	29,380	54,263	120,848		3,156,716	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	223,828	28,929	60,342			3,711,829	50
52	Delivery Room & Labor Room	42,704	7,671	9,267			2,621,746	52
53	Anesthesiology	31,739	26,481	9,175			184,240	53
54	Radiology-Diagnostic	47,800	90	217,445			5,168,312	54
60	Laboratory	26,290	199	498,040			7,365,341	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,795		128,372			2,792,706	65
66	Physical Therapy	1,129		7,938			777,275	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	70,479	1,592	79,461			2,776,150	71
72	Impl. Dev. Charged to Patients			3,886			262,710	72
73	Drugs Charged to Patients	12,980	1,420,900	182,640			3,409,833	73
74	Renal Dialysis		910	23,869			359,111	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	10,174	585	4,805			1,548,137	90
91	Emergency	202,114	34,487	152,888		490,776	8,609,700	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)	1,050,298	1,623,811	2,026,880	1,705,405	490,776	76,113,587	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,951	8				2,592,038	192
194	OUTPATIENT PHARMACY	13	637,963				1,888,019	194
194.01	PUBLIC RELATIONS						204,191	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,052,262	2,261,782	2,026,880	1,705,405	490,776	80,797,835	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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		21,009,048					30
31	Intensive Care Unit		4,809,205					31
40	Subprovider - IPF		7,551,528					40
43	Nursery		3,156,716					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,711,829					50
52	Delivery Room & Labor Room		2,621,746					52
53	Anesthesiology		184,240					53
54	Radiology-Diagnostic		5,168,312					54
60	Laboratory		7,365,341					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,792,706					65
66	Physical Therapy		777,275					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients		2,776,150					71
72	Impl. Dev. Charged to Patients		262,710					72
73	Drugs Charged to Patients		3,409,833					73
74	Renal Dialysis		359,111					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,548,137					90
91	Emergency	-490,776	8,118,924					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)	-490,776	75,622,811					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		2,592,038					192
194	OUTPATIENT PHARMACY		1,888,019					194
194.01	PUBLIC RELATIONS		204,191					194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	-490,776	80,307,059					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		4,573	6,873	11,446	11,446		4
5	Administrative & General		621,453	934,105	1,555,558	1,539	1,557,097	5
6	Maintenance & Repairs							6
7	Operation of Plant		263,983	396,790	660,773	588	143,723	7
8	Laundry & Linen Service		10,334	15,532	25,866	24	11,737	8
9	Housekeeping		24,178	36,341	60,519	369	51,573	9
10	Dietary		31,643	47,562	79,205	113	25,481	10
11	Cafeteria		13,472	20,250	33,722	106	32,123	11
12	Maintenance of Personnel							12
13	Nursing Administration		22,956	34,505	57,461	285	35,895	13
14	Central Services & Supply		15,438	23,204	38,642	90	16,498	14
15	Pharmacy		12,893	19,379	32,272	351	39,654	15
16	Medical Records & Library		47,872	71,956	119,828	149	28,471	16
17	Social Service		7,460	11,214	18,674	211	30,617	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd						9,458	22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		205,318	308,612	513,930	2,315	281,837	30
31	Intensive Care Unit		38,746	58,239	96,985	618	69,670	31
40	Subprovider - IPF		79,848	120,019	199,867	799	91,051	40
43	Nursery		10,469	15,735	26,204	423	48,979	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		76,193	114,525	190,718	362	46,469	50
52	Delivery Room & Labor Room		31,194	46,887	78,081	335	39,799	52
53	Anesthesiology		2,694	4,050	6,744	6	1,655	53
54	Radiology-Diagnostic		39,446	59,291	98,737	595	84,058	54
60	Laboratory		46,361	69,685	116,046	611	120,042	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32,174	48,360	80,534		44,815	65
66	Physical Therapy		14,013	21,063	35,076	93	11,682	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients						50,580	71
72	Impl. Dev. Charged to Patients						4,988	72
73	Drugs Charged to Patients						34,560	73
74	Renal Dialysis						6,443	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		18,484	27,784	46,268	206	22,797	90
91	Emergency		66,757	100,343	167,100	1,092	124,973	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)		1,737,952	2,612,304	4,350,256	11,280	1,509,628	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		144,515	217,219	361,734	75	20,825	192
194	OUTPATIENT PHARMACY		4,887	7,345	12,232	64	22,841	194
194.01	PUBLIC RELATIONS					27	3,803	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,887,354	2,836,868	4,724,222	11,446	1,557,097	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	805,084						7
8	Laundry & Linen Service	8,342	45,969					8
9	Housekeeping	19,517		131,978				9
10	Dietary	25,543		4,337	134,679			10
11	Cafeteria	10,875		1,847		78,673		11
12	Maintenance of Personnel							12
13	Nursing Administration	18,531		3,147		1,952	117,271	13
14	Central Services & Supply	12,462		2,116		1,520		14
15	Pharmacy	10,407		1,767		3,023		15
16	Medical Records & Library	38,644		6,562		2,154		16
17	Social Service	6,022		1,023		1,687		17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	165,737	25,105	28,142	76,298	21,847	46,196	30
31	Intensive Care Unit	31,277	3,852	5,311	9,733	4,346	9,190	31
40	Subprovider - IPF	64,456	13,755	10,945	48,648	8,469	17,907	40
43	Nursery	8,451	3,257	1,435		3,508	7,419	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	61,505		10,444		3,106	6,568	50
52	Delivery Room & Labor Room	25,180		4,276		2,774	5,865	52
53	Anesthesiology	2,175		369		124		53
54	Radiology-Diagnostic	31,842		5,407		5,622		54
60	Laboratory	37,424		6,355		5,552		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	25,972		4,410				65
66	Physical Therapy	11,312		1,921		683		66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	14,921		2,534		2,538	5,367	90
91	Emergency	53,888		9,151		8,871	18,759	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)	684,483	45,969	111,499	134,679	77,776	117,271	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	116,656		19,809				192
194	OUTPATIENT PHARMACY	3,945		670		599		194
194.01	PUBLIC RELATIONS					298		194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	805,084	45,969	131,978	134,679	78,673	117,271	202

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	SUBTOTAL	
		14	15	16	17	22	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	71,328						14
15	Pharmacy		87,474					15
16	Medical Records & Library			195,808				16
17	Social Service				58,234			17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					9,458		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,251	2,010	36,035	31,802		1,246,505	30
31	Intensive Care Unit	7,333	599	7,502	4,880		251,296	31
40	Subprovider - IPF	596	198	13,901	17,425		488,017	40
43	Nursery	2,459	1,136	5,243	4,127		112,641	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,173	1,119	5,830			341,294	50
52	Delivery Room & Labor Room	2,895	297	895			160,397	52
53	Anesthesiology	2,151	1,024	886			15,134	53
54	Radiology-Diagnostic	3,240	3	21,009			250,513	54
60	Laboratory	1,782	8	48,097			335,917	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	189		12,403			168,323	65
66	Physical Therapy	77		767			61,611	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	4,778	62	7,677			63,097	71
72	Impl. Dev. Charged to Patients			375			5,363	72
73	Drugs Charged to Patients	880	54,953	17,646			108,039	73
74	Renal Dialysis		35	2,306			8,784	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	690	23	464			95,808	90
91	Emergency	13,701	1,334	14,772			413,641	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)	71,195	62,801	195,808	58,234		4,126,380	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	132					519,231	192
194	OUTPATIENT PHARMACY	1	24,673				65,025	194
194.01	PUBLIC RELATIONS						4,128	194.01
200	Cross Foot Adjustments					9,458	9,458	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	71,328	87,474	195,808	58,234	9,458	4,724,222	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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,246,505					30
31	Intensive Care Unit		251,296					31
40	Subprovider - IPF		488,017					40
43	Nursery		112,641					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		341,294					50
52	Delivery Room & Labor Room		160,397					52
53	Anesthesiology		15,134					53
54	Radiology-Diagnostic		250,513					54
60	Laboratory		335,917					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		168,323					65
66	Physical Therapy		61,611					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients		63,097					71
72	Impl. Dev. Charged to Patients		5,363					72
73	Drugs Charged to Patients		108,039					73
74	Renal Dialysis		8,784					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		95,808					90
91	Emergency		413,641					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)		4,126,380					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		519,231					192
194	OUTPATIENT PHARMACY		65,025					194
194.01	PUBLIC RELATIONS		4,128					194.01
200	Cross Foot Adjustments		9,458					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,724,222					202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	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	390,858						1
2	Cap Rel Costs-Mvble Equip		390,858					2
4	Employee Benefits Department	947	947	42,358,202				4
5	Administrative & General	128,699	128,699	5,701,486	-13,021,568	67,776,267		5
6	Maintenance & Repairs							6
7	Operation of Plant	54,669	54,669	2,177,559		6,255,887	206,543	7
8	Laundry & Linen Service	2,140	2,140	87,710		510,893	2,140	8
9	Housekeeping	5,007	5,007	1,368,301		2,244,857	5,007	9
10	Dietary	6,553	6,553	418,744		1,109,145	6,553	10
11	Cafeteria	2,790	2,790	391,125		1,398,218	2,790	11
12	Maintenance of Personnel							12
13	Nursing Administration	4,754	4,754	1,056,422		1,562,406	4,754	13
14	Central Services & Supply	3,197	3,197	332,513		718,120	3,197	14
15	Pharmacy	2,670	2,670	1,299,472		1,726,053	2,670	15
16	Medical Records & Library	9,914	9,914	550,708		1,239,280	9,914	16
17	Social Service	1,545	1,545	781,166		1,332,677	1,545	17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					411,681		22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	42,520	42,520	8,543,000		12,267,391	42,520	30
31	Intensive Care Unit	8,024	8,024	2,288,196		3,032,564	8,024	31
40	Subprovider - IPF	16,536	16,536	2,958,150		3,963,198	16,536	40
43	Nursery	2,168	2,168	1,566,536		2,131,934	2,168	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,779	15,779	1,340,125		2,022,680	15,779	50
52	Delivery Room & Labor Room	6,460	6,460	1,239,545		1,732,347	6,460	52
53	Anesthesiology	558	558	21,291		72,023	558	53
54	Radiology-Diagnostic	8,169	8,169	2,203,528		3,658,843	8,169	54
60	Laboratory	9,601	9,601	2,262,800		5,225,137	9,601	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,663	6,663			1,950,705	6,663	65
66	Physical Therapy	2,902	2,902	345,791		508,470	2,902	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients					2,201,628		71
72	Impl. Dev. Charged to Patients					217,111		72
73	Drugs Charged to Patients					1,504,298		73
74	Renal Dialysis					280,450		74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	3,828	3,828	764,688		992,277	3,828	90
91	Emergency	13,825	13,825	4,042,803		5,439,756	13,825	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	359,918	359,918	41,741,659	-13,021,568	65,710,029	175,603	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	29,928	29,928	278,962		906,480	29,928	192
194	OUTPATIENT PHARMACY	1,012	1,012	235,922		994,220	1,012	194
194.01	PUBLIC RELATIONS			101,659		165,538		194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,887,354	2,836,868	7,891,854		13,021,568	7,457,806	202
203	Unit Cost Multiplier (Wkst. B, Part I)	4.828746	7.258053	0.186312		0.192126	36.107764	203
204	Cost to be allocated (Per Wkst. B, Part II)			11,446		1,557,097	805,084	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000270		0.022974	3.897900	205

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

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	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	39,556						8
9	Housekeeping		199,396					9
10	Dietary		6,553	114,685				10
11	Cafeteria		2,790		52,786			11
12	Maintenance of Personnel							12
13	Nursing Administration		4,754		1,310	776,978		13
14	Central Services & Supply		3,197		1,020		2,661,045	14
15	Pharmacy		2,670		2,028			15
16	Medical Records & Library		9,914		1,445			16
17	Social Service		1,545		1,132			17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,602	42,520	64,971	14,659	306,080	569,066	30
31	Intensive Care Unit	3,315	8,024	8,288	2,916	60,886	273,560	31
40	Subprovider - IPF	11,836	16,536	41,426	5,682	118,643	22,246	40
43	Nursery	2,803	2,168		2,354	49,152	91,720	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		15,779		2,084	43,514	566,034	50
52	Delivery Room & Labor Room		6,460		1,861	38,858	107,994	52
53	Anesthesiology		558		83		80,264	53
54	Radiology-Diagnostic		8,169		3,772		120,880	54
60	Laboratory		9,601		3,725		66,484	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		6,663				7,069	65
66	Physical Therapy		2,902		458		2,854	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients						178,233	71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients						32,824	73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		3,828		1,703	35,559	25,730	90
91	Emergency		13,825		5,952	124,286	511,121	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	39,556	168,456	114,685	52,184	776,978	2,656,079	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		29,928				4,933	192
194	OUTPATIENT PHARMACY		1,012		402		33	194
194.01	PUBLIC RELATIONS				200			194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	686,320	2,856,944	1,652,746	1,807,568	2,147,215	1,052,262	202
203	Unit Cost Multiplier (Wkst. B, Part I)	17.350592	14.327991	14.411178	34.243322	2.763547	0.395432	203
204	Cost to be allocated (Per Wkst. B, Part II)	45,969	131,978	134,679	78,673	117,271	71,328	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.162125	0.661889	1.174338	1.490414	0.150932	0.026805	205

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	I&R PROGRAM COSTS ASSIGNED TIME			
		15	16	17	22			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	2,394,532						15
16	Medical Records & Library		177,549,198					16
17	Social Service			39,556				17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd				100			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	55,029	32,670,087	21,602				30
31	Intensive Care Unit	16,403	6,801,675	3,315				31
40	Subprovider - IPF	5,415	12,603,270	11,836				40
43	Nursery	31,104	4,753,265	2,803				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,627	5,285,783					50
52	Delivery Room & Labor Room	8,121	811,788					52
53	Anesthesiology	28,035	803,657					53
54	Radiology-Diagnostic	95	19,047,364					54
60	Laboratory	211	43,628,302					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		11,244,929					65
66	Physical Therapy		695,348					66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	1,685	6,960,494					71
72	Impl. Dev. Charged to Patients		340,429					72
73	Drugs Charged to Patients	1,504,299	15,998,568					73
74	Renal Dialysis	963	2,090,842					74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	619	420,941					90
91	Emergency	36,511	13,392,456		100			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,719,117	177,549,198	39,556	100			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	8						192
194	OUTPATIENT PHARMACY	675,407						194
194.01	PUBLIC RELATIONS							194.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,261,782	2,026,880	1,705,405	490,776			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.944561	0.011416	43.113687	4,907.760000			203
204	Cost to be allocated (Per Wkst. B, Part II)	87,474	195,808	58,234	9,458			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.036531	0.001103	1.472191	94.580000			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	21,009,048		21,009,048		21,009,048	30
31	Intensive Care Unit	4,809,205		4,809,205		4,809,205	31
40	Subprovider - IPF	7,551,528		7,551,528		7,551,528	40
43	Nursery	3,156,716		3,156,716		3,156,716	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,711,829		3,711,829		3,711,829	50
52	Delivery Room & Labor Room	2,621,746		2,621,746		2,621,746	52
53	Anesthesiology	184,240		184,240		184,240	53
54	Radiology-Diagnostic	5,168,312		5,168,312		5,168,312	54
60	Laboratory	7,365,341		7,365,341		7,365,341	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,792,706		2,792,706		2,792,706	65
66	Physical Therapy	777,275		777,275		777,275	66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	2,776,150		2,776,150		2,776,150	71
72	Impl. Dev. Charged to Patients	262,710		262,710		262,710	72
73	Drugs Charged to Patients	3,409,833		3,409,833		3,409,833	73
74	Renal Dialysis	359,111		359,111		359,111	74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	1,548,137		1,548,137		1,548,137	90
91	Emergency	8,118,924		8,118,924		8,118,924	91
92	Observation Beds (Non-Distinct Part)	1,171,764		1,171,764		1,171,764	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	76,794,575		76,794,575		76,794,575	200
201	Less Observation Beds	1,171,764		1,171,764		1,171,764	201
202	Total (line 200 minus line 201)	75,622,811		75,622,811		75,622,811	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	30,955,015		30,955,015				30
31	Intensive Care Unit	6,801,675		6,801,675				31
40	Subprovider - IPF	12,603,270		12,603,270				40
43	Nursery	4,753,265		4,753,265				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,930,439	2,355,344	5,285,783	0.702229	0.702229	0.702229	50
52	Delivery Room & Labor Room	802,788	9,000	811,788	3.229594	3.229594	3.229594	52
53	Anesthesiology	455,890	347,767	803,657	0.229252	0.229252	0.229252	53
54	Radiology-Diagnostic	6,451,540	12,595,824	19,047,364	0.271340	0.271340	0.271340	54
60	Laboratory	21,793,684	21,834,618	43,628,302	0.168820	0.168820	0.168820	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,375,601	1,869,328	11,244,929	0.248352	0.248352	0.248352	65
66	Physical Therapy	327,716	367,632	695,348	1.117822	1.117822	1.117822	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	4,939,097	2,021,397	6,960,494	0.398844	0.398844	0.398844	71
72	Impl. Dev. Charged to Patients	245,690	94,739	340,429	0.771703	0.771703	0.771703	72
73	Drugs Charged to Patients	13,798,402	2,200,166	15,998,568	0.213134	0.213134	0.213134	73
74	Renal Dialysis	1,974,494	116,348	2,090,842	0.171754	0.171754	0.171754	74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	144,833	276,108	420,941	3.677800	3.677800	3.677800	90
91	Emergency	2,448,308	10,944,148	13,392,456	0.606231	0.606231	0.606231	91
92	Observation Beds (Non-Distinct Part)	96,308	1,618,764	1,715,072	0.683216	0.683216	0.683216	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	120,898,015	56,651,183	177,549,198				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	120,898,015	56,651,183	177,549,198				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		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)	1,246,505		1,246,505	22,878	54.48	6,042	329,168	30
31	Intensive Care Unit	251,296		251,296	3,315	75.81	1,225	92,867	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	488,017		488,017	11,836	41.23	2,698	111,239	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	112,641		112,641	2,803	40.19			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,098,459		2,098,459	40,832		9,965	533,274	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0103** **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**

(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	341,294	5,285,783	0.064568	659,392	42,576	50
52	Delivery Room & Labor Room	160,397	811,788	0.197585	10,557	2,086	52
53	Anesthesiology	15,134	803,657	0.018831	48,363	911	53
54	Radiology-Diagnostic	250,513	19,047,364	0.013152	2,174,290	28,596	54
60	Laboratory	335,917	43,628,302	0.007700	6,473,546	49,846	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,323	11,244,929	0.014969	1,762,694	26,386	65
66	Physical Therapy	61,611	695,348	0.088605	136,094	12,059	66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	63,097	6,960,494	0.009065	2,700,630	24,481	71
72	Impl. Dev. Charged to Patients	5,363	340,429	0.015754	120,297	1,895	72
73	Drugs Charged to Patients	108,039	15,998,568	0.006753	3,602,495	24,328	73
74	Renal Dialysis	8,784	2,090,842	0.004201	1,028,939	4,323	74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	95,808	420,941	0.227604	2,857	650	90
91	Emergency	413,641	13,392,456	0.030886	611,643	18,891	91
92	Observation Beds (Non-Distinct Part)	69,523	1,715,072	0.040536			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,097,444	122,435,973		19,331,797	237,028	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)	22,878		6,042		30
31	Intensive Care Unit	3,315		1,225		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	11,836		2,698		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,803				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	40,832		9,965		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0103** | **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
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0103** | **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

		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	5,285,783			659,392		206,773		50
52	Delivery Room & Labor Room	811,788			10,557		474		52
53	Anesthesiology	803,657			48,363		18,573		53
54	Radiology-Diagnostic	19,047,364			2,174,290		1,434,385		54
60	Laboratory	43,628,302			6,473,546		1,444,635		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,244,929			1,762,694		248,445		65
66	Physical Therapy	695,348			136,094				66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	6,960,494			2,700,630		358,224		71
72	Impl. Dev. Charged to Patients	340,429			120,297		4,608		72
73	Drugs Charged to Patients	15,998,568			3,602,495		243,861		73
74	Renal Dialysis	2,090,842			1,028,939		26,445		74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	420,941			2,857		44,192		90
91	Emergency	13,392,456			611,643		1,074,722		91
92	Observation Beds (Non-Distinct Part)	1,715,072					230,048		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	122,435,973			19,331,797		5,335,385		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	0.702229	206,773			145,202			50
52	Delivery Room & Labor Room	3.229594	474			1,531			52
53	Anesthesiology	0.229252	18,573			4,258			53
54	Radiology-Diagnostic	0.271340	1,434,385			389,206			54
60	Laboratory	0.168820	1,444,635			243,883			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248352	248,445			61,702			65
66	Physical Therapy	1.117822							66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	0.398844	358,224			142,875			71
72	Impl. Dev. Charged to Patients	0.771703	4,608			3,556			72
73	Drugs Charged to Patients	0.213134	243,861		3,120	51,975		665	73
74	Renal Dialysis	0.171754	26,445			4,542			74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3.677800	44,192			162,529			90
91	Emergency	0.606231	1,074,722			651,530			91
92	Observation Beds (Non-Distinct Part)	0.683216	230,048			157,172			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		5,335,385		3,120	2,019,961		665	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		5,335,385		3,120	2,019,961		665	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S103** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	341,294	5,285,783	0.064568			50
52	Delivery Room & Labor Room	160,397	811,788	0.197585			52
53	Anesthesiology	15,134	803,657	0.018831			53
54	Radiology-Diagnostic	250,513	19,047,364	0.013152	53,403	702	54
60	Laboratory	335,917	43,628,302	0.007700	637,527	4,909	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,323	11,244,929	0.014969	36,815	551	65
66	Physical Therapy	61,611	695,348	0.088605	11,516	1,020	66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	63,097	6,960,494	0.009065	3,550	32	71
72	Impl. Dev. Charged to Patients	5,363	340,429	0.015754			72
73	Drugs Charged to Patients	108,039	15,998,568	0.006753	587,812	3,969	73
74	Renal Dialysis	8,784	2,090,842	0.004201			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	95,808	420,941	0.227604			90
91	Emergency	413,641	13,392,456	0.030886	125,854	3,887	91
92	Observation Beds (Non-Distinct Part)		1,715,072				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,027,921	122,435,973		1,456,477	15,070	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S103** | **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
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S103** | **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	5,285,783							50
52	Delivery Room & Labor Room	811,788							52
53	Anesthesiology	803,657							53
54	Radiology-Diagnostic	19,047,364			53,403		2,423		54
60	Laboratory	43,628,302			637,527				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,244,929			36,815		2,132		65
66	Physical Therapy	695,348			11,516				66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	6,960,494			3,550				71
72	Impl. Dev. Charged to Patients	340,429							72
73	Drugs Charged to Patients	15,998,568			587,812				73
74	Renal Dialysis	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	420,941							90
91	Emergency	13,392,456			125,854				91
92	Observation Beds (Non-Distinct Part)	1,715,072							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	122,435,973			1,456,477		4,555		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	0.702229							50
52	Delivery Room & Labor Room	3.229594							52
53	Anesthesiology	0.229252							53
54	Radiology-Diagnostic	0.271340	2,423			657			54
60	Laboratory	0.168820							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248352	2,132			529			65
66	Physical Therapy	1.117822							66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	0.398844							71
72	Impl. Dev. Charged to Patients	0.771703							72
73	Drugs Charged to Patients	0.213134							73
74	Renal Dialysis	0.171754							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3.677800							90
91	Emergency	0.606231							91
92	Observation Beds (Non-Distinct Part)	0.683216							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		4,555			1,186			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		4,555			1,186			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
[XX] PPS
[ ] TEFRA

		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)	1,246,505		1,246,505	22,878	54.48	6,415	349,489	30
31	Intensive Care Unit	251,296		251,296	3,315	75.81	926	70,200	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	488,017		488,017	11,836	41.23	4,841	199,594	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	112,641		112,641	2,803	40.19	1,673	67,238	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,098,459		2,098,459	40,832		13,855	686,521	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0103** **WORKSHEET D PART II**

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

(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	341,294	5,285,783	0.064568	1,120,176	72,328	50
52	Delivery Room & Labor Room	160,397	811,788	0.197585	221,779	43,820	52
53	Anesthesiology	15,134	803,657	0.018831	107,408	2,023	53
54	Radiology-Diagnostic	250,513	19,047,364	0.013152	1,784,510	23,470	54
60	Laboratory	335,917	43,628,302	0.007700	6,124,518	47,159	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,323	11,244,929	0.014969	2,847,393	42,623	65
66	Physical Therapy	61,611	695,348	0.088605	49,930	4,424	66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	63,097	6,960,494	0.009065	1,031,724	9,353	71
72	Impl. Dev. Charged to Patients	5,363	340,429	0.015754	39,103	616	72
73	Drugs Charged to Patients	108,039	15,998,568	0.006753	3,738,794	25,248	73
74	Renal Dialysis	8,784	2,090,842	0.004201			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	95,808	420,941	0.227604	51,183	11,649	90
91	Emergency	413,641	13,392,456	0.030886	541,993	16,740	91
92	Observation Beds (Non-Distinct Part)	69,523	1,715,072	0.040536			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,097,444	122,435,973		17,658,511	299,453	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**
[ ] Title XVIII, Part A **[ ] TEFRA**
[XX] 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
[ ] Title XVIII, Part A [ ] TEFRA
[XX] 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)	22,878		6,415		30
31	Intensive Care Unit	3,315		926		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	11,836		4,841		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,803		1,673		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	40,832		13,855		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0103** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V | [XX] Title XVIII, Part A | [XX] 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
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0103** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [XX] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] 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	5,285,783			1,120,176				50
52	Delivery Room & Labor Room	811,788			221,779				52
53	Anesthesiology	803,657			107,408				53
54	Radiology-Diagnostic	19,047,364			1,784,510				54
60	Laboratory	43,628,302			6,124,518				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,244,929			2,847,393				65
66	Physical Therapy	695,348			49,930				66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	6,960,494			1,031,724				71
72	Impl. Dev. Charged to Patients	340,429			39,103				72
73	Drugs Charged to Patients	15,998,568			3,738,794				73
74	Renal Dialysis	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	420,941			51,183				90
91	Emergency	13,392,456			541,993				91
92	Observation Beds (Non-Distinct Part)	1,715,072							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	122,435,973			17,658,511				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	0.702229							50
52	Delivery Room & Labor Room	3.229594							52
53	Anesthesiology	0.229252							53
54	Radiology-Diagnostic	0.271340							54
60	Laboratory	0.168820							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248352							65
66	Physical Therapy	1.117822							66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	0.398844							71
72	Impl. Dev. Charged to Patients	0.771703							72
73	Drugs Charged to Patients	0.213134							73
74	Renal Dialysis	0.171754							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3.677800							90
91	Emergency	0.606231							91
92	Observation Beds (Non-Distinct Part)	0.683216							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-S103** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[ ] Title XVIII, Part A** **[XX] Title XIX** **[ ] Hospital** **[XX] 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	341,294	5,285,783	0.064568	613	40	50
52	Delivery Room & Labor Room	160,397	811,788	0.197585			52
53	Anesthesiology	15,134	803,657	0.018831			53
54	Radiology-Diagnostic	250,513	19,047,364	0.013152	110,953	1,459	54
60	Laboratory	335,917	43,628,302	0.007700	866,895	6,675	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,323	11,244,929	0.014969	77,236	1,156	65
66	Physical Therapy	61,611	695,348	0.088605	10,220	906	66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients	63,097	6,960,494	0.009065	7,436	67	71
72	Impl. Dev. Charged to Patients	5,363	340,429	0.015754			72
73	Drugs Charged to Patients	108,039	15,998,568	0.006753	880,552	5,946	73
74	Renal Dialysis	8,784	2,090,842	0.004201			74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	95,808	420,941	0.227604			90
91	Emergency	413,641	13,392,456	0.030886	281,793	8,703	91
92	Observation Beds (Non-Distinct Part)		1,715,072				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,027,921	122,435,973		2,235,698	24,952	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S103** | **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
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S103** | **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

		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	5,285,783			613				50
52	Delivery Room & Labor Room	811,788							52
53	Anesthesiology	803,657							53
54	Radiology-Diagnostic	19,047,364			110,953				54
60	Laboratory	43,628,302			866,895				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	11,244,929			77,236				65
66	Physical Therapy	695,348			10,220				66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	6,960,494			7,436				71
72	Impl. Dev. Charged to Patients	340,429							72
73	Drugs Charged to Patients	15,998,568			880,552				73
74	Renal Dialysis	2,090,842							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	420,941							90
91	Emergency	13,392,456			281,793				91
92	Observation Beds (Non-Distinct Part)	1,715,072							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	122,435,973			2,235,698				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	0.702229							50
52	Delivery Room & Labor Room	3.229594							52
53	Anesthesiology	0.229252							53
54	Radiology-Diagnostic	0.271340							54
60	Laboratory	0.168820							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248352							65
66	Physical Therapy	1.117822							66
69	Electrocardiology								69
71	Medical Supplies Charged to Patients	0.398844							71
72	Impl. Dev. Charged to Patients	0.771703							72
73	Drugs Charged to Patients	0.213134							73
74	Renal Dialysis	0.171754							74
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	3.677800							90
91	Emergency	0.606231							91
92	Observation Beds (Non-Distinct Part)	0.683216							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

Check	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[ ] 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)	22,878	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,878	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)	21,602	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)	6,042	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)	21,009,048	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)	21,009,048	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)	21,009,048	37

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)					918.31	38
39	Program general inpatient routine service cost (line 9 x line 38)					5,548,429	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)					5,548,429	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	4,809,205	3,315	1,450.74	1,225	1,777,157	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,276,766	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					12,602,352	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	422,035	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	237,028	51
52	Total Program excludable cost (sum of lines 50 and 51)	659,063	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	11,943,289	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)					1,276	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					918.31	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,171,764	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	1,246,505	21,009,048	0.059332	1,171,764	69,523	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[ ] 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)	11,836	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,836	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)	11,836	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)	2,698	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)	7,551,528	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)	7,551,528	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)	7,551,528	37

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)	638.01	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,721,351	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,721,351	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	347,129	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,068,480	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	111,239	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	15,070	51
52	Total Program excludable cost (sum of lines 50 and 51)	126,309	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,942,171	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**
	[ ] Title XVIII, Part A	**[ ] 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)	22,878	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,878	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)	21,602	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)	6,415	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)	2,803	15
16	Nursery days (title V or XIX only)	1,673	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)	21,009,048	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)	21,009,048	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)	21,009,048	37

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [XX] 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)					918.31	38
39	Program general inpatient routine service cost (line 9 x line 38)					5,890,959	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)					5,890,959	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)	3,156,716	2,803	1,126.19	1,673	1,884,116	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,809,205	3,315	1,450.74	926	1,343,385	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					5,563,969	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					14,682,429	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	486,927	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	299,453	51
52	Total Program excludable cost (sum of lines 50 and 51)	786,380	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	13,896,049	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**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,276	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

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[XX] IPF**	**[ ] SNF**		**[ ] TEFRA**
Boxes:	**[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)	11,836	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,836	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)	11,836	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)	4,841	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)	7,551,528	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)	7,551,528	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)	7,551,528	37

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)	638.01	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,088,606	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,088,606	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	568,965	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,657,571	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	199,594	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	24,952	51
52	Total Program excludable cost (sum of lines 50 and 51)	224,546	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	3,433,025	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: 14-0103** **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		8,395,315		30
31	Intensive Care Unit		2,582,100		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.702229	659,392	463,044	50
52	Delivery Room & Labor Room	3.229594	10,557	34,095	52
53	Anesthesiology	0.229252	48,363	11,087	53
54	Radiology-Diagnostic	0.271340	2,174,290	589,972	54
60	Laboratory	0.168820	6,473,546	1,092,864	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248352	1,762,694	437,769	65
66	Physical Therapy	1.117822	136,094	152,129	66
69	Electrocardiology				69
71	Medical Supplies Charged to Patients	0.398844	2,700,630	1,077,130	71
72	Impl. Dev. Charged to Patients	0.771703	120,297	92,834	72
73	Drugs Charged to Patients	0.213134	3,602,495	767,814	73
74	Renal Dialysis	0.171754	1,028,939	176,724	74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	3.677800	2,857	10,507	90
91	Emergency	0.606231	611,643	370,797	91
92	Observation Beds (Non-Distinct Part)	0.683216			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		19,331,797	5,276,766	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		19,331,797		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S103** **WORKSHEET D-3**

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
40	Subprovider - IPF		2,879,414		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.702229			50
52	Delivery Room & Labor Room	3.229594			52
53	Anesthesiology	0.229252			53
54	Radiology-Diagnostic	0.271340	53,403	14,490	54
60	Laboratory	0.168820	637,527	107,627	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248352	36,815	9,143	65
66	Physical Therapy	1.117822	11,516	12,873	66
69	Electrocardiology				69
71	Medical Supplies Charged to Patients	0.398844	3,550	1,416	71
72	Impl. Dev. Charged to Patients	0.771703			72
73	Drugs Charged to Patients	0.213134	587,812	125,283	73
74	Renal Dialysis	0.171754			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	3.677800			90
91	Emergency	0.606231	125,854	76,297	91
92	Observation Beds (Non-Distinct Part)	0.683216			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,456,477	347,129	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,456,477		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0103** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[XX] 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		9,455,438		30
31	Intensive Care Unit		2,056,413		31
40	Subprovider - IPF				40
43	Nursery		2,629,666		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.702229	1,120,176	786,620	50
52	Delivery Room & Labor Room	3.229594	221,779	716,256	52
53	Anesthesiology	0.229252	107,408	24,623	53
54	Radiology-Diagnostic	0.271340	1,784,510	484,209	54
60	Laboratory	0.168820	6,124,518	1,033,941	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248352	2,847,393	707,156	65
66	Physical Therapy	1.117822	49,930	55,813	66
69	Electrocardiology				69
71	Medical Supplies Charged to Patients	0.398844	1,031,724	411,497	71
72	Impl. Dev. Charged to Patients	0.771703	39,103	30,176	72
73	Drugs Charged to Patients	0.213134	3,738,794	796,864	73
74	Renal Dialysis	0.171754			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	3.677800	51,183	188,241	90
91	Emergency	0.606231	541,993	328,573	91
92	Observation Beds (Non-Distinct Part)	0.683216			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		17,658,511	5,563,969	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		17,658,511		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S103** **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
40	Subprovider - IPF		5,474,388		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.702229	613	430	50
52	Delivery Room & Labor Room	3.229594			52
53	Anesthesiology	0.229252			53
54	Radiology-Diagnostic	0.271340	110,953	30,106	54
60	Laboratory	0.168820	866,895	146,349	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248352	77,236	19,182	65
66	Physical Therapy	1.117822	10,220	11,424	66
69	Electrocardiology				69
71	Medical Supplies Charged to Patients	0.398844	7,436	2,966	71
72	Impl. Dev. Charged to Patients	0.771703			72
73	Drugs Charged to Patients	0.213134	880,552	187,676	73
74	Renal Dialysis	0.171754			74
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	3.677800			90
91	Emergency	0.606231	281,793	170,832	91
92	Observation Beds (Non-Distinct Part)	0.683216			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,235,698	568,965	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,235,698		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)	6,983,503			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,986,183			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)	125,469			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	590,893			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	154.50			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)	3.92			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	1.06			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	4.98			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	4.01			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	4.01			12
13	Total allowable FTE count for the prior year	4.02			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.92			14
15	Sum of lines 12 through 14 divided by 3	3.98			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	3.98			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.025761			19
20	Prior year resident to bed ratio (see instructions)	0.025518			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.025518			21
22	IME payment adjustment (see instructions)	132,385			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)	-0.97			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)	132,385			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)	0.2069			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6370			31
32	Sum of lines 30 and 31	0.8439			32
33	Allowable disproportionate share percentage (see instructions)	0.5884			33
34	Disproportionate share adjustment (see instructions)	1,319,441			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)	5,326,798	4,117,425		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	3,984,152	1,037,818		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	5,021,970			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)	1,448			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	160			41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	1,384			41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	11.05			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	956			43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)	0.098679			44
45	Average weekly cost for dialysis treatments (see instructions)	405.45			45
46	Total additional payment (line 45 times line 44 times line 41.01)	55,374			46

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	15,624,325			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)	15,624,325			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	866,441			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)	96,859			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 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)				58
59	Total (sum of amounts on lines 49 through 58)	16,587,625			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	16,587,625			61
62	Deductibles billed to program beneficiaries	929,903			62
63	Coinsurance billed to program beneficiaries	85,904			63
64	Allowable bad debts (see instructions)	541,947			64
65	Adjusted reimbursable bad debts (see instructions)	352,266			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	507,911			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	15,924,084			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)	-38,624			70.93
70.94	HRR adjustment amount (see instructions)	-125,314			70.94
71	Amount due provider (see instructions)	15,760,146			71
71.01	Sequestration adjustment (see instructions)	315,203			71.01
72	Interim payments	18,624,975			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	-3,180,032			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	988,246			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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	665			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,019,961			2
3	PPS payments	1,566,387			3
4	Outlier payment (see instructions)	1,555			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)	665			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	3,120			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)	3,120			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)	3,120			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	2,455			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)	665			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)	1,567,942			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	345,039			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)	1,223,568			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	13,348			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,236,916			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,236,916			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)	167,465			34
35	Adjusted reimbursable bad debts (see instructions)	108,852			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	162,620			36
37	Subtotal (see instructions)	1,345,768			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)	1,345,768			40
40.01	Sequestration adjustment (see instructions)	26,915			40.01
41	Interim payments	1,289,366			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	29,487			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)	1,186			2
3	PPS payments	1,017			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)	1,017			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	214			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)	803			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)	803			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	803			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)	803			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)	803			40
40.01	Sequestration adjustment (see instructions)	16			40.01
41	Interim payments	787			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

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				16,011,678		1,199,059	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				133,597		90,307	2
3	List separately each retroactive lump sum adjustment		.01	06/04/2014	616,800			3.01
	amount based on subsequent revision of the interim		.02	01/06/2015	1,862,900			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		2,479,700			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)				18,624,975		1,289,366	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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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 [XX] 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				1,925,411		787	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				64,091			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)				1,989,502		787	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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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)	5,917	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	7,267	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,247	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	24,917	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	177,549,198	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	11,450,847	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)	809,213	8
9	Sequestration adjustment amount (see instructions)	16,184	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	793,029	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	914,347	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-121,318	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)	2,220,072	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)	32.427397	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)	2,220,072	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)	2,220,072	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,220,072	18
19	Deductibles	182,619	19
20	Subtotal (line 18 minus line 19)	2,037,453	20
21	Coinsurance	73,144	21
22	Subtotal (line 20 minus line 21)	1,964,309	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	63,452	23
24	Adjusted reimbursable bad debts (see instructions)	41,244	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	63,452	25
26	Subtotal (sum of lines 22 and 24)	2,005,553	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)	2,005,553	31
31.01	Sequestration adjustment (see instructions)	40,111	31.01
32	Interim payments	1,989,502	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-24,060	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 Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] 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	14,141,517		8
9	Ancillary service charges	17,658,511		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)	31,800,028		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)	31,800,028		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	31,800,028		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 (LESS INPATIENT COSTS)			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	OUTPATIENT 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	5,474,388		8
9	Ancillary service charges	2,235,698		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)	7,710,086		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)	7,710,086		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	7,710,086		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

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			3.03	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))			1.06	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)			4.09	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			4.01	6
7	Enter the lesser of line 5 or line 6			4.01	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	3.77	3.77	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	3.77	3.77	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	3.77		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	4.02		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	4.02		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	3.94		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	3.94		17
18	Per resident amount	93,294.00	93,294.00		18
19	Approved amount for resident costs		367,578	367,578	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)			367,578	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	9,965	1,247		26
27	Total inpatient days (see instructions)	36,808	36,808		27
28	Ratio of inpatient days to total inpatient days	0.270729	0.033879		28
29	Program direct GME amount	99,514	12,453		29
30	Reduction for direct GME payments for Medicare Advantage		1,760		30
31	Net Program direct GME amount			110,207	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)			2,090,842	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)			14,670,832	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)			14,670,832	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			2,021,812	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			2,021,812	44
45	Total reasonable cost (sum of lines 41 and 44)			16,692,644	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.878880	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.121120	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			110,207	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			96,859	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			13,348	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)	12,197	12,012		26
27	Total inpatient days (see instructions)	36,808	36,808		27
28	Ratio of inpatient days to total inpatient days	0.331368	0.326342		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	1,304,177				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	20,083,698				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	1,250,594				7
8	Prepaid expenses	2,052,765				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	24,691,234				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	32,497,025				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)	32,497,025				30
	OTHER ASSETS					
31	Investments	70,841				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	45,242,559				34
35	Total other assets (sum of lines 31-34)	45,313,400				35
36	Total assets (sum of lines 11, 30 and 35)	102,501,659				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	9,830,656				37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	89,301				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,854,968				44
45	Total current liabilities (sum of lines 37 thru 44)	12,774,925				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	18,554,945				49
50	Total long term liabilities (sum of lines 46 thru 49)	18,554,945				50
51	Total liabilities (sum of lines 45 and 50)	31,329,870				51
	CAPITAL ACCOUNTS					
52	General fund balance	71,171,789				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)	71,171,789				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	102,501,659				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		40,843,499			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,637,385			2
3	Total (sum of line 1 and line 2)		38,206,114			3
4	Additions (credit adjustments) (specify)					4
5	GAINS ON INVESTMENTS					5
6	TEMPORARILY RESTRICTED					6
7	CONTRIBUTIONS					7
8	EQUITY TRANSFER FROM SB FOUNDATION	33,460,626				8
9	ASSETS RELEASED	2,135,487				9
10	Total additions (sum of lines 4-9)		35,596,113			10
11	Subtotal (line 3 plus line 10)		73,802,227			11
12	Deductions (debit adjustments) (specify)					12
13	NET ASSETS RELEASED	2,630,438				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,630,438			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		71,171,789			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	GAINS ON INVESTMENTS					5
6	TEMPORARILY RESTRICTED					6
7	CONTRIBUTIONS					7
8	EQUITY TRANSFER FROM SB FOUNDATION					8
9	ASSETS RELEASED					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	NET ASSETS RELEASED					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	32,301,794		32,301,794	1
2	Subprovider IPF	12,662,880		12,662,880	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	44,964,674		44,964,674	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	6,829,845		6,829,845	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,829,845		6,829,845	16
17	Total inpatient routine care services (sum of lines 10 and 16)	51,794,519		51,794,519	17
18	Ancillary services	68,430,713		68,430,713	18
19	Outpatient services		57,376,201	57,376,201	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	OP PHARMACY	1,321,219	937,055	2,258,274	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	121,546,451	58,313,256	179,859,707	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		97,974,054	29
30	Add (specify)			30
31	BAD DEBTS			31
32	BP	29,503		32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		29,503	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)		98,003,557	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	179,859,707	1
2	Less contractual allowances and discounts on patients' accounts	97,593,227	2
3	Net patient revenues (line 1 minus line 2)	82,266,480	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	98,003,557	4
5	Net income from service to patients (line 3 minus line 4)	-15,737,077	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	1,042	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	1,337	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	498,004	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	59,862	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	15,543	21
22	Rental of hosptial space	158,799	22
23	Governmental appropriations		23
24	Other (MISCELLANEOUS INCOME)	1,623,570	24
24.01	Other (ER PRO FEE INCOME)	3,675,956	24.01
24.02	Other (ANEST PRO FEE INCOME)	663,692	24.02
24.03	Other (SISTERS MAINTENANCE)	12,000	24.03
24.04	Other (OTHER RENTAL INCOME)	256,396	24.04
24.05	Other (EMPLOYEES ROOM RENT)	57,832	24.05
24.06	Other (PARTNERS IN HEALTH)	4,262,484	24.06
24.07	Other (CAPITATION REVENUE)		24.07
24.08	Other (CLINIC REVENUE)	624,288	24.08
24.09	Other (CLINIC REVENUES)		24.09
24.10	Other (NET ASSETS RELEASED)	1,211,241	24.10
25	Total other income (sum of lines 6-24)	13,122,046	25
26	Total (line 5 plus line 25)	-2,615,031	26
27.01	Other expenses (LOSS ON SALE OF ASSETS)	22,354	27.01
28	Total other expenses (sum of line 27 and subscripts)	22,354	28
29	Net income (or loss) for the period (line 26 minus line 28)	-2,637,385	29

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0103** **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	715,006	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	6,289	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)	68.42	3
4	Number of interns & residents (see instructions)	3.98	4
5	Indirect medical education percentage (see instructions)	1.66	5
6	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	11,869	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2069	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6370	8
9	Sum of lines 7 and 8	0.8439	9
10	Allowable disproportionate share percentage (see instructions)	0.1864	10
11	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	133,277	11
12	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	866,441	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

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0103** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		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)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		11
12	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		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
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
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
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
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	Physicians' Private Offices							192
194	OUTPATIENT PHARMACY							194
194.01	PUBLIC RELATIONS							194.01
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	26.41		28.04				54.45	30
31	Intensive Care Unit	36.95		27.93				64.88	31
43	Nursery			59.69				59.69	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	12.47	3.91	21.19				37.57	50
52	Delivery Room & Labor Room	1.30	0.06	27.32				28.68	52
53	Anesthesiology	6.02	2.31	13.36				21.69	53
54	Radiology-Diagnostic	11.42	7.53	9.37				28.32	54
60	Laboratory	14.84	3.31	14.04				32.19	60
65	Respiratory Therapy	15.68	2.21	25.32				43.21	65
66	Physical Therapy	19.57		7.18				26.75	66
71	Medical Supplies Charged to Pat	38.80	5.15	14.82				58.77	71
72	Impl. Dev. Charged to Patients	35.34	1.35	11.49				48.18	72
73	Drugs Charged to Patients	22.52	1.54	23.37				47.43	73
74	Renal Dialysis	49.21	1.26					50.47	74
90	Clinic	0.68	10.50	12.16				23.34	90
91	Emergency	4.57	8.02	4.05				16.64	91
92	Observation Beds (Non-Distinct		13.41					13.41	92
200	TOTAL CHARGES	15.79	4.36	14.42				34.57	200

ST. BERNARD HOSPITAL Provider CCN: 14-0103	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 05/28/2015 Run Time: 09:33 Version: 2015.03 (05/21/2015)

REPORT 97 - UTILIZATION STATISTICS - SUBPROVIDER-IPF

		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								
40	Subprovider - IPF	22.79		40.90				63.69	40
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room			0.01				0.01	50
54	Radiology-Diagnostic	0.28	0.01	0.58				0.87	54
60	Laboratory	1.46		1.99				3.45	60
65	Respiratory Therapy	0.33	0.02	0.69				1.04	65
66	Physical Therapy	1.66		1.47				3.13	66
71	Medical Supplies Charged to Pat	0.05		0.11				0.16	71
73	Drugs Charged to Patients	3.67		5.50				9.17	73
91	Emergency	0.94		2.10				3.04	91
200	TOTAL CHARGES	1.19		1.83				3.02	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	1,887,354	2.34	-1,887,354	-4.86			1
2	Cap Rel Costs-Mvble Equip	2,836,868	3.51	-2,836,868	-7.31			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	7,880,408	9.75	-7,880,408	-20.30			4
5	Administrative & General	10,403,755	12.88	-10,403,755	-26.80			5
6	Maintenance & Repairs							6
7	Operation of Plant	5,189,409	6.42	-5,189,409	-13.37			7
8	Laundry & Linen Service	468,686	0.58	-468,686	-1.21			8
9	Housekeeping	1,929,407	2.39	-1,929,407	-4.97			9
10	Dietary	951,923	1.18	-951,923	-2.45			10
11	Cafeteria	1,291,625	1.60	-1,291,625	-3.33			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,308,121	1.62	-1,308,121	-3.37			13
14	Central Services & Supply	617,527	0.76	-617,527	-1.59			14
15	Pharmacy	1,451,674	1.80	-1,451,674	-3.74			15
16	Medical Records & Library	1,016,848	1.26	-1,016,848	-2.62			16
17	Social Service	1,168,462	1.45	-1,168,462	-3.01			17
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	411,681	0.51	-411,681	-1.06			22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	10,161,784	12.58	10,847,264	27.95	21,009,048	26.00	30
31	Intensive Care Unit	2,509,261	3.11	2,299,944	5.93	4,809,205	5.95	31
40	Subprovider - IPF	3,212,192	3.98	4,339,336	11.18	7,551,528	9.35	40
43	Nursery	1,813,866	2.24	1,342,850	3.46	3,156,716	3.91	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,582,281	1.96	2,129,548	5.49	3,711,829	4.59	50
52	Delivery Room & Labor Room	1,423,324	1.76	1,198,422	3.09	2,621,746	3.24	52
53	Anesthesiology	61,312	0.08	122,928	0.32	184,240	0.23	53
54	Radiology-Diagnostic	3,149,562	3.90	2,018,750	5.20	5,168,312	6.40	54
60	Laboratory	4,687,504	5.80	2,677,837	6.90	7,365,341	9.12	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,870,171	2.31	922,535	2.38	2,792,706	3.46	65
66	Physical Therapy	408,969	0.51	368,306	0.95	777,275	0.96	66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients	2,201,628	2.72	574,522	1.48	2,776,150	3.44	71
72	Impl. Dev. Charged to Patients	217,111	0.27	45,599	0.12	262,710	0.33	72
73	Drugs Charged to Patients	1,504,298	1.86	1,905,535	4.91	3,409,833	4.22	73
74	Renal Dialysis	280,450	0.35	78,661	0.20	359,111	0.44	74
76.97	CARDIAC REHABILITATION							76.97
90	Clinic	803,538	0.99	744,599	1.92	1,548,137	1.92	90
91	Emergency	4,519,433	5.59	4,090,267	10.54	8,609,700	10.66	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	492,772	0.61	2,099,266	5.41	2,592,038	3.21	192
194	OUTPATIENT PHARMACY	938,033	1.16	949,986	2.45	1,888,019	2.34	194
194.01	PUBLIC RELATIONS	146,598	0.18	57,593	0.15	204,191	0.25	194.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	80,797,835	100.00			80,797,835	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	341,294	5,285,783	0.064568	659,392	42,576	50
52	Delivery Room & Labor Room	160,397	811,788	0.197585	10,557	2,086	52
53	Anesthesiology	15,134	803,657	0.018831	48,363	911	53
54	Radiology-Diagnostic	250,513	19,047,364	0.013152	2,174,290	28,596	54
60	Laboratory	335,917	43,628,302	0.007700	6,473,546	49,846	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	168,323	11,244,929	0.014969	1,762,694	26,386	65
66	Physical Therapy	61,611	695,348	0.088605	136,094	12,059	66
69	Electrocardiology						69
71	Medical Supplies Charged to Pat	63,097	6,960,494	0.009065	2,700,630	24,481	71
72	Impl. Dev. Charged to Patients	5,363	340,429	0.015754	120,297	1,895	72
73	Drugs Charged to Patients	108,039	15,998,568	0.006753	3,602,495	24,328	73
74	Renal Dialysis	8,784	2,090,842	0.004201	1,028,939	4,323	74
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	95,808	420,941	0.227604	2,857	650	90
91	Emergency	413,641	13,392,456	0.030886	611,643	18,891	91
92	Observation Beds (Non-Distinct	69,523	1,715,072	0.040536			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	2,097,444	122,435,973		19,331,797	237,028	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	1,246,505		1,246,505	22,878	54.48	6,042	329,168	30
31	Intensive Care Unit	251,296		251,296	3,315	75.81	1,225	92,867	31
200	TOTAL	1,497,801		1,497,801	26,193		7,267	422,035	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	422,035
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	237,028
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	659,063
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	1,338
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	7,267
PER DISCHARGE CAPITAL COSTS	492.57

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)	11,943,289
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	30,309,212
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.394

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))	2,068,480
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	4,335,891
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.477

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)	659,063
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.022

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 column 1 less lines 61, 66-68, 74, 94, 95 & 96)	2,015,419
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)	5,308,940
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.380