THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-4009	PERIOD FROM 1/ 1/2008 TO 12/31/2008	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 5/18/2009 TIME 12:42

PART I - 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 BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
RIVER EDGE HOSPITAL 14-4009
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 5/18/2009 TIME 12:42

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PI ENCRYPTION INFORMATION
DATE: 5/18/2009 TIME 12:42

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	-188,855	0	0
100	TOTAL	0	-188,855	0	0

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 respond 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 662 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: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 8311 WEST ROOSEVELT ROAD P.O. BOX:
1.01 CITY: FOREST PARK STATE: IL ZIP CODE: 60130- COUNTY: COOK

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	RIVER EDGE HOSPITAL	14-4009		7/ 1/1967	N	P	O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

		1	2
18	TYPE OF CONTROL	4	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	4
20	SUBPROVIDER	

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. 1

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 1 N N

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 1

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3. / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3. / /

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N / /

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

Line	Description	1	2	3	4
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

Line	Category	%	Y/N
28.03	STAFFING	0.00%	
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	
28.07		0.00%	
28.08		0.00%	
28.09		0.00%	
28.10		0.00%	
28.11		0.00%	
28.12		0.00%	
28.13		0.00%	
28.14		0.00%	
28.15		0.00%	
28.16		0.00%	
28.17		0.00%	
28.18		0.00%	
28.19		0.00%	
28.20		0.00%	

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) N

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N

35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

Line	Description	V 1	XVIII 2	XIX 3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE			

WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N Y
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?

TITLE XIX INPATIENT SERVICES
38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y
38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? N
38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?
IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y
40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
40.02 STREET: P.O. BOX:
40.03 CITY: STATE: ZIP CODE: -
41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH
42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL
EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN
EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE
53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
PREMIUMS: 0
PAID LOSSES: 0
AND/OR SELF INSURANCE: 0
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND
GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS
CONTAINED THEREIN. N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH
42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER?
ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100%
FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS N
ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE
10/1/2002.
58.01 IF LINE 58 COLUMN 1 IS Y, DOES 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. IS
THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC.
412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER
1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD
COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS
OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO.
IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2
"Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?
ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW
FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) Y N

60.01 IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). N N 0

MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL1. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00
62.01						0.00
62.02						0.00
62.03						0.00
62.04						0.00
62.05						0.00
62.06						0.00
62.07						0.00
62.08						0.00
62.09						0.00

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	196	71,736			7,401		29,187
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	196	71,736			7,401		29,187
12	TOTAL	196	71,736			7,401		29,187
13	RPCH VISITS							
17	OTHER LONG TERM CARE	14	5,124					
25	TOTAL	210						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS TITLE XIX OBSERVATION BEDS ADMITTED 5.01	NOT ADMITTED 5.02	TOTAL ALL PATS 6	TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			39,330				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			39,330				
12	TOTAL			39,330				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			4,834				
25	TOTAL							
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					657	1,640	2,784
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		244.89			657	1,640	2,784
13	RPCH VISITS							
17	OTHER LONG TERM CARE		15.62					1
25	TOTAL		260.51					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
	SALARIES						
1	TOTAL SALARY	14,635,589		14,635,589			
2	NON-PHYSICIAN ANESTHETIST PART A						
3	NON-PHYSICIAN ANESTHETIST PART B						
4	PHYSICIAN - PART A						
4.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5	PHYSICIAN - PART B						
5.01	NON-PHYSICIAN - PART B						
6	INTERNS & RESIDENTS (APPRVD)						
6.01	CONTRACT SERVICES, I&R						
7	HOME OFFICE PERSONNEL						
8	SNF						
8.01	EXCLUDED AREA SALARIES	765,889	265,674	1,031,563			
	OTHER WAGES & RELATED COSTS						
9	CONTRACT LABOR:						
9.01	PHARMACY SERVICES UNDER CONTRACT						
9.02	LABORATORY SERVICES UNDER CONTRACT						
9.03	MANAGEMENT & ADMINISTRATIVE UNDER CONRACT						
10	CONTRACT LABOR: PHYS PART A						
10.01	TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11	HOME OFFICE SALARIES & WAGE RELATED COSTS						
12	HOME OFFICE: PHYS PART A						
12.01	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
	WAGE RELATED COSTS						
13	WAGE-RELATED COSTS (CORE)						CMS 339
14	WAGE-RELATED COSTS (OTHER)						CMS 339
15	EXCLUDED AREAS						CMS 339
16	NON-PHYS ANESTHETIST PART A						CMS 339
17	NON-PHYS ANESTHETIST PART B						CMS 339
18	PHYSICIAN PART A						CMS 339
18.01	PART A TEACHING PHYSICIANS						CMS 339
19	PHYSICIAN PART B						CMS 339
19.01	WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
20	INTERNS & RESIDENTS (APPRVD)						CMS 339
	OVERHEAD COSTS - DIRECT SALARIES						
21	EMPLOYEE BENEFITS	141,549		141,549			
22	ADMINISTRATIVE & GENERAL	3,372,869	-265,674	3,107,195			
22.01	A & G UNDER CONTRACT						
23	MAINTENANCE & REPAIRS						
24	OPERATION OF PLANT	177,823	-33,551	144,272			
25	LAUNDRY & LINEN SERVICE						
26	HOUSEKEEPING		33,551	33,551			
26.01	HOUSEKEEPING UNDER CONTRACT						
27	DIETARY	358,554		358,554			
27.01	DIETARY UNDER CONTRACT						
28	CAFETERIA						
29	MAINTENANCE OF PERSONNEL						
30	NURSING ADMINISTRATION	964,460		964,460			
31	CENTRAL SERVICE AND SUPPLY						
32	PHARMACY						
33	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	212,806		212,806			
34	SOCIAL SERVICE	1,022,264		1,022,264			
35	OTHER GENERAL SERVICE						

	PART III - HOSPITAL WAGE INDEX SUMMARY	1	2	3	4	5	6
1	NET SALARIES	14,635,589		14,635,589			
2	EXCLUDED AREA SALARIES	765,889	265,674	1,031,563			
3	SUBTOTAL SALARIES	13,869,700	-265,674	13,604,026			
4	SUBTOTAL OTHER WAGES & RELATED COSTS						
5	SUBTOTAL WAGE-RELATED COSTS						
6	TOTAL	13,869,700	-265,674	13,604,026			
7	NET SALARIES						
8	EXCLUDED AREA SALARIES						
9	SUBTOTAL SALARIES						
10	SUBTOTAL OTHER WAGES & RELATED COSTS						
11	SUBTOTAL WAGE-RELATED COSTS						
12	TOTAL						
13	TOTAL OVERHEAD COSTS	6,250,325	-265,674	5,984,651			

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		702,645	702,645	1,475,339	2,177,984
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		28,885	28,885	53,199	82,084
5	0500	EMPLOYEE BENEFITS	141,549	1,259,808	1,401,357	5,053	1,406,410
6	0600	ADMINISTRATIVE & GENERAL	3,372,869	5,491,882	8,864,751	-2,297,352	6,567,399
8	0800	OPERATION OF PLANT	177,823	1,631,476	1,809,299	-780,169	1,029,130
9	0900	LAUNDRY & LINEN SERVICE				83,671	83,671
10	1000	HOUSEKEEPING				704,260	704,260
11	1100	DIETARY	358,554	707,299	1,065,853		1,065,853
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	964,460	175,898	1,140,358	-2,751	1,137,607
17	1700	MEDICAL RECORDS & LIBRARY	212,806	145,790	358,596		358,596
18	1800	SOCIAL SERVICE	1,022,264	121,329	1,143,593		1,143,593
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	7,306,801	898,384	8,205,185	413,664	8,618,849
36	3600	OTHER LONG TERM CARE	765,889	159,283	925,172		925,172
		ANCILLARY SRVC COST CNTRS					
41	4100	RADIOLOGY-DIAGNOSTIC					
44	4400	LABORATORY		198,860	198,860		198,860
53	5300	ELECTROCARDIOLOGY					
56	5600	DRUGS CHARGED TO PATIENTS		1,040,512	1,040,512		1,040,512
59	3950	OUTPATIENT PSYCH					
		OUTPAT SERVICE COST CNTRS					
60	6000	CLINIC	312,574	32,810	345,384		345,384
		SPEC PURPOSE COST CENTERS					
95		SUBTOTALS	14,635,589	12,594,861	27,230,450	-345,086	26,885,364
		NONREIMBURS COST CENTERS					
98	9800	PHYSICIANS' PRIVATE OFFICES					
100	7950	COMMUNITY RELATIONS				345,086	345,086
101		TOTAL	14,635,589	12,594,861	27,230,450	-0-	27,230,450

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-1,194,639	983,345
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	175,856	257,940
5	0500	EMPLOYEE BENEFITS	-216,502	1,189,908
6	0600	ADMINISTRATIVE & GENERAL	-1,607,487	4,959,912
8	0800	OPERATION OF PLANT	-1,587	1,027,543
9	0900	LAUNDRY & LINEN SERVICE		83,671
10	1000	HOUSEKEEPING		704,260
11	1100	DIETARY	-39,239	1,026,614
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION	-26,249	1,111,358
17	1700	MEDICAL RECORDS & LIBRARY	-203	358,393
18	1800	SOCIAL SERVICE		1,143,593
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-398,580	8,220,269
36	3600	OTHER LONG TERM CARE	-145,861	779,311
		ANCILLARY SRVC COST CNTRS		
41	4100	RADIOLOGY-DIAGNOSTIC		
44	4400	LABORATORY		198,860
53	5300	ELECTROCARDIOLOGY		
56	5600	DRUGS CHARGED TO PATIENTS		1,040,512
59	3950	OUTPATIENT PSYCH		
		OUTPAT SERVICE COST CNTRS		
60	6000	CLINIC	-36,653	308,731
		SPEC PURPOSE COST CENTERS		
95		SUBTOTALS	-3,491,144	23,394,220
		NONREIMBURS COST CENTERS		
98	9800	PHYSICIANS' PRIVATE OFFICES		
100	7950	COMMUNITY RELATIONS		345,086
101		TOTAL	-3,491,144	23,739,306

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
53	ELECTROCARDIOLOGY	5300	
56	DRUGS CHARGED TO PATIENTS	5600	
59	OUTPATIENT PSYCH	3950	OTHER ANCILLARY SERVICE COST CENTERS
	OUTPAT SERVICE COST		
60	CLINIC	6000	
	SPEC PURPOSE COST CE		
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	COMMUNITY RELATIONS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

	EXPLANATION OF RECLASSIFICATION	CODE (1)	INCREASE COST CENTER	LINE NO	SALARY	OTHER
		1	2	3	4	5
1	LEASE\RENTAL	A	NEW CAP REL COSTS-BLDG & FIXT	3		1,464,000
2			NEW CAP REL COSTS-MVBLE EQUIP	4		36,430
3						
4	PHYSICIAN FEES	B	ADULTS & PEDIATRICS	25		413,664
5	COMMUNTIY RELATIONS	C	COMMUNITY RELATIONS	100	265,674	79,412
6	INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3		11,339
7	LAUNDRY	E	LAUNDRY & LINEN SERVICE	9		83,671
8			HOUSEKEEPING	10	33,551	670,709
9	INTEREST	F	NEW CAP REL COSTS-MVBLE EQUIP	4		16,769
10	ADMINISTRATION MISCELLANEOUS	G	EMPLOYEE BENEFITS	5		5,053
11			OPERATION OF PLANT	8		18,512
36	TOTAL RECLASSIFICATIONS				299,225	2,799,559

(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.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	CODE (1)	DECREASE COST CENTER	LINE NO	SALARY	OTHER	A-7 REF
	1		6	7	8	9	10
1	LEASE\RENTAL	A	ADMINISTRATIVE & GENERAL	6		1,486,929	10
2			OPERATION OF PLANT	8		10,750	10
3			NURSING ADMINISTRATION	14		2,751	
4	PHYSICIAN FEES	B	ADMINISTRATIVE & GENERAL	6		413,664	
5	COMMUNTIY RELATIONS	C	ADMINISTRATIVE & GENERAL	6	265,674	79,412	
6	INSURANCE	D	ADMINISTRATIVE & GENERAL	6		11,339	12
7	LAUNDRY	E	OPERATION OF PLANT	8	33,551	754,380	
8							
9	INTEREST	F	ADMINISTRATIVE & GENERAL	6		16,769	11
10	ADMINISTRATION MISCELLANEOUS	G	ADMINISTRATIVE & GENERAL	6		23,565	
11							
36	TOTAL RECLASSIFICATIONS				299,225	2,799,559	

(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.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : LEASE\RENTAL

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	1,464,000	ADMINISTRATIVE & GENERAL	6	1,486,929
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	36,430	OPERATION OF PLANT	8	10,750
3.00			0	NURSING ADMINISTRATION	14	2,751
TOTAL RECLASSIFICATIONS FOR CODE A			1,500,430			1,500,430

RECLASS CODE: B
EXPLANATION : PHYSICIAN FEES

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	413,664	ADMINISTRATIVE & GENERAL	6	413,664
TOTAL RECLASSIFICATIONS FOR CODE B			413,664			413,664

RECLASS CODE: C
EXPLANATION : COMMUNTIY RELATIONS

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	COMMUNITY RELATIONS	100	345,086	ADMINISTRATIVE & GENERAL	6	345,086
TOTAL RECLASSIFICATIONS FOR CODE C			345,086			345,086

RECLASS CODE: D
EXPLANATION : INSURANCE

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	11,339	ADMINISTRATIVE & GENERAL	6	11,339
TOTAL RECLASSIFICATIONS FOR CODE D			11,339			11,339

RECLASS CODE: E
EXPLANATION : LAUNDRY

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	LAUNDRY & LINEN SERVICE	9	83,671	OPERATION OF PLANT	8	787,931
2.00	HOUSEKEEPING	10	704,260			0
TOTAL RECLASSIFICATIONS FOR CODE E			787,931			787,931

RECLASS CODE: F
EXPLANATION : INTEREST

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	16,769	ADMINISTRATIVE & GENERAL	6	16,769
TOTAL RECLASSIFICATIONS FOR CODE F			16,769			16,769

RECLASS CODE: G
EXPLANATION : ADMINISTRATION MISCELLANEOUS

INCREASE LINE	COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	EMPLOYEE BENEFITS	5	5,053	ADMINISTRATIVE & GENERAL	6	23,565
2.00	OPERATION OF PLANT	8	18,512			0
TOTAL RECLASSIFICATIONS FOR CODE G			23,565			23,565

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	1,263,514	264,836		264,836		1,528,350	
7	SUBTOTAL	1,263,514	264,836		264,836		1,528,350	
8	RECONCILING ITEMS							
9	TOTAL	1,263,514	264,836		264,836		1,528,350	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
		GROSS ASSETS	CAPITLIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
5	TOTAL				1.000000				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	-897,660	1,464,000		11,339	402,116	3,550	983,345
4	NEW CAP REL COSTS-MV	206,891	36,430	16,769	-2,150			257,940
5	TOTAL	-690,769	1,500,430	16,769	9,189	402,116	3,550	1,241,285

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	296,979				402,116	3,550	702,645
4	NEW CAP REL COSTS-MV	28,885						28,885
5	TOTAL	325,864				402,116	3,550	731,530

* All lines numbers except line 5 are to be consistent with Workhsheet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-903,690			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-526,104			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-39,239	DIETARY	11	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-203	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES	B	-1,587	OPERATION OF PLANT	8	
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		**COST CENTER DELETED**	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES	A	269,361	NEW CAP REL COSTS-BLDG &	3	9
32	DEPRECIATION-NEW MOVABLE EQUIP	A	178,006	NEW CAP REL COSTS-MVBLE E	4	9
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	MISC INCOME	B	-9,626	ADMINISTRATIVE & GENERAL	6	
38	PATIENT TRANSPORTATION	A	-66,498	ADMINISTRATIVE & GENERAL	6	
39	PATIENT TRANSPORTATION	A	-36,653	CLINIC	60	
40	PATIENT TRANSPORTATION	A	-26,249	NURSING ADMINISTRATION	14	
41						
42						
43	CORPORTATE INSURANCE ADJ.-AUTO	A	-2,150	NEW CAP REL COSTS-MVBLE E	4	12
44	MISCELLANEOUS NON ALLOWABLES	A	-162,184	ADMINISTRATIVE & GENERAL	6	
45	LOST VALUABLES	A	-873	ADULTS & PEDIATRICS	25	
46	HOSPITAL LEASE	A	-1,464,000	NEW CAP REL COSTS-BLDG &	3	9
47	CORPORATE INSURANCE ADJ. - MEDICAL	A	-71,017	EMPLOYEE BENEFITS	5	
48	CORPORATE INSURANCE ADJ. - WORKER'S	A	-89,636	EMPLOYEE BENEFITS	5	
48.01	CORPORATE INSURANCE ADJ. - GEN. LIAB	A	-139,586	ADMINISTRATIVE & GENERAL	6	
48.03	EDUCATION COSTS	A	-177,261	ADULTS & PEDIATRICS	25	
48.04	EDUCATION COSTS	A	-121,753	OTHER LONG TERM CARE	36	
48.05						
49	PHYSICIAN BENEFITS	A	-55,849	EMPLOYEE BENEFITS	5	
49.01	PHYSICIAN COSTS	A	-44,353	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-3,491,144			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(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 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
	1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE EXPENSE	876,840	1,402,944	-526,104	
2							
3							
4							
5		TOTALS		876,840	1,402,944	-526,104	

* THE AMOUNTS ON LINES 1-4 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 ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	B	PSI	100.00	PSI	100.00	HEALTHCARE
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP 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 A 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.

	WKSHT A LINE NO. 1		COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	25	AGGR		413,664	10,380	403,284	154,100	2,608	193,218	9,661
2	36	AGGR		51,520		51,520	154,100	370	27,412	1,371
3										
4	6	AGGR		659,136	659,136					
5										
6										
7										
8										
9										
10										
11										
12										
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28										
29										
30										
101		TOTAL		1,124,320	669,516	454,804		2,978	220,630	11,032

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	25	AGGR						193,218	210,066	220,446
2	36	AGGR						27,412	24,108	24,108
3										
4	6	AGGR								659,136
5										
6										
7										
8										
9										
10										
11										
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20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL						220,630	234,174	903,690

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	2	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	6	PATIENT	DAYS	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	6	PATIENT	DAYS	ENTERED
12	CAFETERIA	9	FTE'S	SERVED	ENTERED
14	NURSING ADMINISTRATION	10	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	ENTERED
18	SOCIAL SERVICE	6	PATIENT	DAYS	ENTERED

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT
		0	3	4	5	5a.00	6	8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &	983,345	983,345					
004	NEW CAP REL COSTS-MVBLE E	257,940		257,940				
005	EMPLOYEE BENEFITS	1,189,908	5,946	1,625	1,197,479			
006	ADMINISTRATIVE & GENERAL	4,959,912	170,989	46,742	256,713	5,434,356	5,434,356	
008	OPERATION OF PLANT	1,027,543	58,354	15,952	11,920	1,113,769	330,655	1,444,424
009	LAUNDRY & LINEN SERVICE	83,671	11,312	3,092		98,075	29,116	21,842
010	HOUSEKEEPING	704,260	12,110	3,311	2,772	722,453	214,481	23,384
011	DIETARY	1,026,614	57,633	15,755	29,623	1,129,625	335,362	111,283
012	CAFETERIA							
014	NURSING ADMINISTRATION	1,111,358	55,285	15,113	79,683	1,261,439	374,495	106,751
017	MEDICAL RECORDS & LIBRARY	358,393	9,615	2,628	17,582	388,218	115,254	18,565
018	SOCIAL SERVICE	1,143,593	19,859	5,429	84,458	1,253,339	372,090	38,346
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	8,220,269	471,226	128,814	603,676	9,423,985	2,797,784	909,892
036	OTHER LONG TERM CARE	779,311	47,290	12,927	63,277	902,805	268,024	91,311
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY	198,860	2,962	810		202,632	60,157	5,720
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS	1,040,512	8,441	2,308		1,051,261	312,097	16,299
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	308,731	6,073	1,660	25,825	342,289	101,618	11,726
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	23,394,220	937,095	256,166	1,175,529	23,324,246	5,311,133	1,355,119
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		39,760			39,760	11,804	76,773
100	COMMUNITY RELATIONS	345,086	6,490	1,774	21,950	375,300	111,419	12,532
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	23,739,306	983,345	257,940	1,197,479	23,739,306	5,434,356	1,444,424

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		9	10	11	12	14	17	18
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE	149,033						
010	HOUSEKEEPING		960,318					
011	DIETARY		76,377	1,652,647				
012	CAFETERIA							
014	NURSING ADMINISTRATION		73,267			1,815,952		
017	MEDICAL RECORDS & LIBRARY		12,742				534,779	
018	SOCIAL SERVICE		26,318					1,690,093
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	132,720	624,490	1,471,755		1,571,626	459,558	1,505,103
036	OTHER LONG TERM CARE	16,313	62,670	180,892		165,739	16,843	184,990
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY		3,926				8,912	
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS		11,187				30,197	
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		8,048			78,587	19,269	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	149,033	899,025	1,652,647		1,815,952	534,779	1,690,093
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		52,692					
100	COMMUNITY RELATIONS		8,601					
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	149,033	960,318	1,652,647		1,815,952	534,779	1,690,093

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	18,896,913		18,896,913
036	OTHER LONG TERM CARE	1,889,587		1,889,587
	ANCILLARY SRVC COST CNTRS			
041	RADIOLOGY-DIAGNOSTIC			
044	LABORATORY	281,347		281,347
053	ELECTROCARDIOLOGY			
056	DRUGS CHARGED TO PATIENTS	1,421,041		1,421,041
059	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	561,537		561,537
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	23,050,425		23,050,425
	NONREIMBURS COST CENTERS			
098	PHYSICIANS' PRIVATE OFFIC	181,029		181,029
100	COMMUNITY RELATIONS	507,852		507,852
101	CROSS FOOT ADJUSTMENT			
102	NEGATIVE COST CENTER			
103	TOTAL	23,739,306		23,739,306

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENEFITS 5	ADMINISTRATIVE & GENERAL 6	OPERATION OF PLANT 8
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		5,946	1,625	7,571	7,571		
006	ADMINISTRATIVE & GENERAL	19,113	170,989	46,742	236,844	1,622	238,466	
008	OPERATION OF PLANT		58,354	15,952	74,306	75	14,509	88,890
009	LAUNDRY & LINEN SERVICE		11,312	3,092	14,404		1,278	1,344
010	HOUSEKEEPING		12,110	3,311	15,421	18	9,411	1,439
011	DIETARY		57,633	15,755	73,388	187	14,716	6,848
012	CAFETERIA							
014	NURSING ADMINISTRATION		55,285	15,113	70,398	503	16,433	6,569
017	MEDICAL RECORDS & LIBRARY		9,615	2,628	12,243	111	5,057	1,143
018	SOCIAL SERVICE		19,859	5,429	25,288	534	16,327	2,360
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		471,226	128,814	600,040	3,819	122,773	55,995
036	OTHER LONG TERM CARE		47,290	12,927	60,217	400	11,761	5,619
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY		2,962	810	3,772		2,640	352
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS		8,441	2,308	10,749		13,695	1,003
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		6,073	1,660	7,733	163	4,459	722
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	19,113	937,095	256,166	1,212,374	7,432	233,059	83,394
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		39,760		39,760		518	4,725
100	COMMUNITY RELATIONS		6,490	1,774	8,264	139	4,889	771
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	19,113	983,345	257,940	1,260,398	7,571	238,466	88,890

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		9	10	11	12	14	17	18
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE	17,026						
010	HOUSEKEEPING		26,289					
011	DIETARY		2,091	97,230				
012	CAFETERIA							
014	NURSING ADMINISTRATION		2,006			95,909		
017	MEDICAL RECORDS & LIBRARY		349				18,903	
018	SOCIAL SERVICE		720					45,229
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	15,162	17,097	86,588		83,005	16,241	40,278
036	OTHER LONG TERM CARE	1,864	1,716	10,642		8,753	596	4,951
	ANCILLARY SRVC COST CNTRS							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY		107				315	
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATIENTS		306				1,069	
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		220			4,151	682	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	17,026	24,612	97,230		95,909	18,903	45,229
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		1,442					
100	COMMUNITY RELATIONS		235					
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	17,026	26,289	97,230		95,909	18,903	45,229

	COST CENTER DESCRIPTION	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		25	26	27
	GENERAL SERVICE COST CNTR			
003	NEW CAP REL COSTS-BLDG &			
004	NEW CAP REL COSTS-MVBLE E			
005	EMPLOYEE BENEFITS			
006	ADMINISTRATIVE & GENERAL			
008	OPERATION OF PLANT			
009	LAUNDRY & LINEN SERVICE			
010	HOUSEKEEPING			
011	DIETARY			
012	CAFETERIA			
014	NURSING ADMINISTRATION			
017	MEDICAL RECORDS & LIBRARY			
018	SOCIAL SERVICE			
	INPAT ROUTINE SRVC CNTRS			
025	ADULTS & PEDIATRICS	1,040,998		1,040,998
036	OTHER LONG TERM CARE	106,519		106,519
	ANCILLARY SRVC COST CNTRS			
041	RADIOLOGY-DIAGNOSTIC			
044	LABORATORY	7,186		7,186
053	ELECTROCARDIOLOGY			
056	DRUGS CHARGED TO PATIENTS	26,822		26,822
059	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
060	CLINIC	18,130		18,130
	SPEC PURPOSE COST CENTERS			
095	SUBTOTALS	1,199,655		1,199,655
	NONREIMBURS COST CENTERS			
098	PHYSICIANS' PRIVATE OFFIC	46,445		46,445
100	COMMUNITY RELATIONS	14,298		14,298
101	CROSS FOOT ADJUSTMENTS			
102	NEGATIVE COST CENTER			
103	TOTAL	1,260,398		1,260,398

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE E (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)
		3	4	5	6a.00	6	8
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	139,092					
004	NEW CAP REL COSTS-MVB		133,468				
005	EMPLOYEE BENEFITS	841	841	14,494,040			
006	ADMINISTRATIVE & GENE	24,186	24,186	3,107,195	-5,434,356	18,304,950	
008	OPERATION OF PLANT	8,254	8,254	144,272		1,113,769	105,811
009	LAUNDRY & LINEN SERVI	1,600	1,600			98,075	1,600
010	HOUSEKEEPING	1,713	1,713	33,551		722,453	1,713
011	DIETARY	8,152	8,152	358,554		1,129,625	8,152
012	CAFETERIA						
014	NURSING ADMINISTRATIO	7,820	7,820	964,460		1,261,439	7,820
017	MEDICAL RECORDS & LIB	1,360	1,360	212,806		388,218	1,360
018	SOCIAL SERVICE	2,809	2,809	1,022,264		1,253,339	2,809
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	66,654	66,654	7,306,801		9,423,985	66,654
036	OTHER LONG TERM CARE	6,689	6,689	765,889		902,805	6,689
	ANCILLARY SRVC COST C						
041	RADIOLOGY-DIAGNOSTIC						
044	LABORATORY	419	419			202,632	419
053	ELECTROCARDIOLOGY						
056	DRUGS CHARGED TO PATI	1,194	1,194			1,051,261	1,194
059	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST C						
060	CLINIC	859	859	312,574		342,289	859
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	132,550	132,550	14,228,366	-5,434,356	17,889,890	99,269
	NONREIMBURS COST CENT						
098	PHYSICIANS' PRIVATE O	5,624				39,760	5,624
100	COMMUNITY RELATIONS	918	918	265,674		375,300	918
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	983,345	257,940	1,197,479		5,434,356	1,444,424
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	7.069745	1.932598	.082619		.296879	13.650981
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III			7,571		238,466	88,890
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)			.000522		.013027	.840083

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1997)CONTD

I PROVIDER NO: I PERIOD: I PREPARED 5/18/2009

COST ALLOCATION - STATISTICAL BASIS I 14-4009 I FROM 1/ 1/2008 I WORKSHEET B-1

I I TO 12/31/2008 I

	COST CENTER DESCRIPTION	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E
		(PATIENT DAYS	(SQUARE)FEET	(PATIENT)DAYS	(FTE'S)SERVED	(DIRECT)NRSING HRS	( ) GROSS CHARGES	(PATIENT)DAYS)
		9	10	11	12	14	17	18
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVI	44,164						
010	HOUSEKEEPING		102,498					
011	DIETARY		8,152	44,164				
012	CAFETERIA				20,905			
014	NURSING ADMINISTRATIO		7,820		1,425	355,993		
017	MEDICAL RECORDS & LIB		1,360		466		60,284,546	
018	SOCIAL SERVICE		2,809		1,454			44,164
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	39,330	66,654	39,330	14,812	308,096	51,805,015	39,330
036	OTHER LONG TERM CARE	4,834	6,689	4,834	1,562	32,491	1,898,614	4,834
	ANCILLARY SRVC COST C							
041	RADIOLOGY-DIAGNOSTIC							
044	LABORATORY		419				1,004,675	
053	ELECTROCARDIOLOGY							
056	DRUGS CHARGED TO PATI		1,194		400		3,404,067	
059	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST C							
060	CLINIC		859		741	15,406	2,172,175	
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	44,164	95,956	44,164	20,860	355,993	60,284,546	44,164
	NONREIMBURS COST CENT							
098	PHYSICIANS' PRIVATE O		5,624					
100	COMMUNITY RELATIONS		918		45			
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	149,033	960,318	1,652,647		1,815,952	534,779	1,690,093
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	3.374536	9.369139	37.420682		5.101089	.008871	38.268567
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	17,026	26,289	97,230		95,909	18,903	45,229
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.385518	.256483	2.201567		.269413	.000314	1.024115

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	18,896,913		18,896,913	210,066	19,106,979
36	OTHER LONG TERM CARE	1,889,587		1,889,587	24,108	1,913,695
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY	281,347		281,347		281,347
53	ELECTROCARDIOLOGY					
56	DRUGS CHARGED TO PATIENTS	1,421,041		1,421,041		1,421,041
59	OUTPATIENT PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	561,537		561,537		561,537
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,050,425		23,050,425	234,174	23,284,599
102	LESS OBSERVATION BEDS					
103	TOTAL	23,050,425		23,050,425	234,174	23,284,599

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT-IENT RATIO 10	PPS INPAT-IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	51,805,015		51,805,015			
36	OTHER LONG TERM CARE	1,898,614		1,898,614			
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY	1,004,675		1,004,675	.280038	.280038	.280038
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS	3,404,067		3,404,067	.417454	.417454	.417454
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		2,172,175	2,172,175	.258514	.258514	.258514
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	58,112,371	2,172,175	60,284,546			
102	LESS OBSERVATION BEDS						
103	TOTAL	58,112,371	2,172,175	60,284,546			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	18,896,913		18,896,913	210,066	19,106,979
36	OTHER LONG TERM CARE	1,889,587		1,889,587	24,108	1,913,695
	ANCILLARY SRVC COST CNTRS					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY	281,347		281,347		281,347
53	ELECTROCARDIOLOGY					
56	DRUGS CHARGED TO PATIENTS	1,421,041		1,421,041		1,421,041
59	OUTPATIENT PSYCH					
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	561,537		561,537		561,537
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,050,425		23,050,425	234,174	23,284,599
102	LESS OBSERVATION BEDS					
103	TOTAL	23,050,425		23,050,425	234,174	23,284,599

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT-IENT RATIO 10	PPS INPAT-IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	51,805,015		51,805,015			
36	OTHER LONG TERM CARE	1,898,614		1,898,614			
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY	1,004,675		1,004,675	.280038	.280038	.280038
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS	3,404,067		3,404,067	.417454	.417454	.417454
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		2,172,175	2,172,175	.258514	.258514	.258514
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	58,112,371	2,172,175	60,284,546			
102	LESS OBSERVATION BEDS						
103	TOTAL	58,112,371	2,172,175	60,284,546			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY	281,347	7,186	274,161			281,347
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS	1,421,041	26,822	1,394,219			1,421,041
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	561,537	18,130	543,407			561,537
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	2,263,925	52,138	2,211,787			2,263,925
102	LESS OBSERVATION BEDS						
103	TOTAL	2,263,925	52,138	2,211,787			2,263,925

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	1,004,675	.280038	.280038
53	ELECTROCARDIOLOGY			
56	DRUGS CHARGED TO PATIENTS	3,404,067	.417454	.417454
59	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,172,175	.258514	.258514
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	6,580,917		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,580,917		

Health Financial Systems MCRIF32 FOR RIVER EDGE HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-4009 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/18/2009 WORKSHEET C PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY	281,347	7,186	274,161	719	15,901	264,727
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS	1,421,041	26,822	1,394,219	2,682	80,865	1,337,494
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	561,537	18,130	543,407	1,813	31,518	528,206
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	2,263,925	52,138	2,211,787	5,214	128,284	2,130,427
102	LESS OBSERVATION BEDS						
103	TOTAL	2,263,925	52,138	2,211,787	5,214	128,284	2,130,427

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
41	RADIOLOGY-DIAGNOSTIC			
44	LABORATORY	1,004,675	.263495	.279322
53	ELECTROCARDIOLOGY			
56	DRUGS CHARGED TO PATIENTS	3,404,067	.392911	.416666
59	OUTPATIENT PSYCH			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	2,172,175	.243169	.257679
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	6,580,917		
102	LESS OBSERVATION BEDS			
103	TOTAL	6,580,917		

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II)	SWING BED ADJUSTMENT	REDUCED CAP RELATED COST	CAPITAL REL COST (B,III)	SWING BED ADJUSTMENT	REDUCED CAP RELATED COST
		1	2	3	4	5	6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS				1,040,998		1,040,998
101	TOTAL				1,040,998		1,040,998

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	39,330	7,401			26.47	195,904
101	TOTAL	39,330	7,401				195,904

I PROVIDER NO:	I PERIOD:	I PREPARED 5/18/2009
I 14-4009	I FROM 1/ 1/2008	I WORKSHEET D
I COMPONENT NO:	I TO 12/31/2008	I PART II
I 14-4009	I	I

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	CAPITAL COSTS 6
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY		7,186	1,004,675	214,036		
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS		26,822	3,404,067	966,307		
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		18,130	2,172,175			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		52,138	6,580,917	1,180,343		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO:	I PERIOD:	I PREPARED 5/18/2009
I 14-4009	I FROM 1/ 1/2008	I WORKSHEET D
I COMPONENT NO:	I TO 12/31/2008	I PART II
I 14-4009	I	I

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO 7	COSTS 8
	ANCILLARY SRVC COST CNTRS		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY	.007153	1,531
53	ELECTROCARDIOLOGY		
56	DRUGS CHARGED TO PATIENTS	.007879	7,614
59	OUTPATIENT PSYCH		
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.008346	
	OTHER REIMBURS COST CNTRS		
101	TOTAL		9,145

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS
TITLE XVIII, PART A

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS					39,330	
101	TOTAL					39,330	

APPORTIONMENT OF INPATIENT ROUTINE
SERVICE OTHER PASS THROUGH COSTS
TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS 7	INPAT PROGRAM PASS THRU COST 8
25	ADULTS & PEDIATRICS	7,401	
101	TOTAL	7,401	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

I PROVIDER NO: 14-4009 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/18/2009
I COMPONENT NO: 14-4009 I WORKSHEET D PART IV

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS						
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

I PROVIDER NO: 14-4009 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/18/2009
I COMPONENT NO: 14-4009 WORKSHEET D PART IV

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
41	RADIOLOGY-DIAGNOSTIC							
44	LABORATORY			1,004,675			214,036	
53	ELECTROCARDIOLOGY							
56	DRUGS CHARGED TO PATIENTS			3,404,067			966,307	
59	OUTPATIENT PSYCH							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			2,172,175				
	OTHER REIMBURS COST CNTRS							
101	TOTAL			6,580,917			1,180,343	

TITLE XVIII, PART A HOSPITAL PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
53	ELECTROCARDIOLOGY						
56	DRUGS CHARGED TO PATIENTS						
59	OUTPATIENT PSYCH						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

TITLE XVIII PART A HOSPITAL PPS

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	39,330
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	39,330
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	39,330
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	7,401
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	19,106,979
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	19,106,979
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	51,805,015
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	51,805,015
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.368825
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,317.19
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	19,106,979

TITLE XVIII PART A HOSPITAL PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	485.81
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3,595,480
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3,595,480

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	463,327
49	TOTAL PROGRAM INPATIENT COSTS	4,058,807
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	195,904
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	9,145
52	TOTAL PROGRAM EXCLUDABLE COST	205,049
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	3,853,758
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL PPS

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

Line	Description	1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

Line	Description	1
83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	485.81
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Line	Description	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST		19,106,979			
87	NEW CAPITAL-RELATED COST	1,040,998	19,106,979	.054483		
88	NON PHYSICIAN ANESTHETIST		19,106,979			
89	MEDICAL EDUCATION		19,106,979			
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	39,330
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	39,330
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	39,330
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	29,187
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
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)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	18,896,913
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	18,896,913
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	51,805,015
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	51,805,015
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.364770
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,317.19
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	18,896,913

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	480.47
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	14,023,478
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	14,023,478

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,111,648
49	TOTAL PROGRAM INPATIENT COSTS	15,135,126
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	