HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT — WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY — PARTS I & II

INTERMEDIARY USE ONLY:	[ ]	AUDITED	DATE RECEIVED	_____	[ ]	INITIAL	[ ]	RE-OPENING
	[ ]	DESK REVIEWED	INTERMEDIARY NO.	_____	[ ]	FINAL	[ ]	MCR CODE

PART I - CERTIFICATION

CHECK APPLICABLE BOX __ ELECTRONICALLY FILED COST REPORT DATE: _____
__ MANUALLY SUBMITTED COST REPORT TIME: _____

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ALEXIAN BROTHERS BEHAVIORAL HEALTH (14-4031) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2008 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.

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

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		58558	25335		1
2	SUBPROVIDER I					2
3	SWING BED - SNF					3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	HEALTH CLINIC					9
100	TOTAL		58558	25335		100

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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1	STREET: 1650 MOON LAKE BOULEVARD		P.O.BOX:		1
1.01	CITY: HOFFMAN ESTATES	STATE: IL	ZIP CODE: 60194	COUNTY: COOK	1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
2	HOSPITAL	ALEXIAN BROTHERS BEHAVIORAL HEALTH	14-4031	06/28/1990	N	P	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF							4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC							14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16
17	COST REPORTING PERIOD (MM/DD/YYYY)			FROM: 01/01/2008	TO: 12/31/2008			17
				1	2			
18	TYPE OF CONTROL			1				18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	4	19
20	SUBPROVIDER I		20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING 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.		21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?	NO	21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.		21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	1 N Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	1	21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	1	21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO	22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO	23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.		23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.		23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.		24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.		24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO	25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO	25.01
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.	NO	25.02
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.	NO	25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO	25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME 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)	NO NO	25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT 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)	NO NO	25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. 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.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
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.	NO			27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
	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 INSTRUCTIONS)				
28.03	STAFFING	0.00	N		28.03
28.04	RECRUITMENT	0.00	N		28.04
28.05	RETENTION OF EMPLOYEES	0.00	N		28.05
28.06	TRAINING	0.00	N		28.06
28.07	OTHER (SPECIFY)				28.07
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?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	NO			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.				30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?				30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE 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)				30.03
30.04	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. 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.				30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
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.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL	V 1	XVIII 2	XIX 3	
36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA — WORKSHEET S-2 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	YES 149019	40
40.01	NAME: ENTER NAME IN COLUMN 1 FI/CONTRACTOR'S NAME: WPS	FI/CONTRACTOR'S NUMBER: 52280	40.01
40.02	STREET: 3040 SALT CREEK LANE	P.O.BOX:	40.02
40.03	CITY: ARLINGTON HEIGHTS	STATE: IL ZIP CODE: 60005	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A '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	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?				NO			52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.				NO			52.01
53	IF THIS IS 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.							53
53.01	MDH PERIOD:	BEGINNING:		ENDING:				53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:							54
	PREMIUMS: 721705 PAID LOSSES: AND/OR SELF INSURANCE:							
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.				NO			54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.				NO			55

		DATE	Y/N	LIMIT	Y/N	FEES	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	NO	57
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% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	NO	58
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 IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? 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 INSTRUCTIONS)			58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	59

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2 (CONTINUED)

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)	YES				60
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.)	NO	NO			60.01

MULTICAMPUS

61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO				61
	IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.					
		COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5

SETTLEMENT DATA

63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	YES	02/28/2009			63

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

	COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	I/P DAYS / O/P VISITS / TRIPS: CAH PATIENT HOURS	TITLE V	TITLE XVIII	LTCH NONCOVERED DAYS	TITLE XIX	OBS. BEDS ADMITTED	
		1	2	2.01	3	4	4.01	5	5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	137	50142			18149		4410		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	137	50142			18149		4410		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	137	50142			18149		4410		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I									24
25	TOTAL	137								25
26	OBSERVATION BED DAYS									26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA — WORKSHEET S-3 PART I (CONTINUED)

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS: OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES: TOTAL 7	LESS I&R REPL PHYS 8	LESS I&R NON-ANES 8	NET 9	FULL TIME EQUIV: EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		45933									1
2	HMO XIX											2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF											3
4	HOSPITAL ADULTS & PEDS - SWING BED NF											4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		45933									5
6	INTENSIVE CARE UNIT											6
7	CORONARY CARE UNIT											7
8	BURN INTENSIVE CARE UNIT											8
9	SURGICAL INTENSIVE CARE UNIT											9
10	OTHER SPECIAL CARE (SPECIFY)											10
11	NURSERY											11
12	TOTAL HOSPITAL		45933							456.29		12
13	RPCH VISITS											13
14	SUBPROVIDER I											14
15	SKILLED NURSING FACILITY											15
16	NURSING FACILITY											16
17	OTHER LONG TERM CARE											17
18	HOME HEALTH AGENCY											18
20	ASC (DISTINCT PART)											20
21	HOSPICE (DISTINCT PART)											21
23	O/P REHAB PROVIDER											23
24	RHC I											24
25	TOTAL									456.29		25
26	OBSERVATION BED DAYS											26
27	AMBULANCE TRIPS											27
28	EMPLOYEE DISCOUNT DAYS											28

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

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1295	395	5457	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		1295	395	5457	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART II

	PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	28318262			949093.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A	121903			2080.00			4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	6119601			153834.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS	1343560			43508.00		HOME OFFICE WPS	11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	5359870					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	1118986					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	250236			8922.00			21
22	ADMINISTRATIVE & GENERAL	4951051			164598.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	123986			2017.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	57195						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	203179	-22522		7256.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		22522		916.00			28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	1143653			32510.40			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	340336			16244.80			33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART III

	PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	28318262		28318262	949093.00	29.84	1
2	EXCLUDED AREA SALARIES	6119601		6119601	153834.00	39.78	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	22198661		22198661	795259.00	27.91	3
4	SUBTOTAL OTHER WAGES & REL COSTS	1343560		1343560	43508.00	30.88	4
5	SUBTOTAL WAGE-RELATED COSTS	5359870		5359870		24.15%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	28902091		28902091	838767.00	34.46	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	7069636		7069636	232464.20	30.41	13

NHCMQ DEMONSTRATION STATISTICAL DATA WORKSHEET S-7
STATISTICAL DATA

	GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1 RATE	DAYS	SERVICES ON OR AFTER JANUARY 1 RATE	DAYS	TOTAL	
	1	2	3	3.01	4	4.01	5	
1	RVC/RUC							1
2	RVB/RUB							2
3	RVA/RUA							3
3.01	RUX							3.01
3.02	RUL							3.02
4	RHD/RVC							4
5	RHC/RVB							5
6	RHB/RVA							6
6.01	RVX							6.01
6.02	RVL							6.02
7	RHA/RHC							7
8	RMC/RHB							8
9	RMB/RHA							9
9.01	RHX							9.01
9.02	RHL							9.02
10	RMA/RMC							10
11	RLB/RMB							11
12	RLA/RMA							12
12.01	RMX							12.01
12.02	RML							12.02
13	SE3/RLB							13
14	SE2/RLA							14
14.01	RLX							14.01
15	SE1/SE3							15
16	SSC/SE2							16
17	SSB/SE1							17
18	SSA/SSC							18
19	CD2/SSB							19
20	CD1/SSA							20
21	CC2							21
22	CC1							22
23	CB2							23
24	CB1							24
25	CA2							25
26	CA1							26
27	IB2							27
28	IB1							28
29	IA2							29
30	IA1							30
31	BB2							31
32	BB1							32
33	BA2							33
34	BA1							34
35	PE2							35
36	PE1							36
37	PD2							37
38	PD1							38
39	PC2							39
40	PC1							40
41	PB2							41
42	PB1							42
43	PA2							43
44	PA1							44
45	DEFAULT RATE							45
46	TOTAL							46

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1234659	1234659	229623	1464282	1511746	2976028	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP								4
5	0500	EMPLOYEE BENEFITS	250236	4393332	4643568	-26240	4617328		4617328	5
6	0600	ADMINISTRATIVE & GENERAL	4951051	12393806	17344857	-882399	16462458	-2631724	13830734	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	123986	1524047	1648033	-43888	1604145	52113	1656258	8
9	0900	LAUNDRY & LINEN SERVICE								9
10	1000	HOUSEKEEPING	57195	768438	825633		825633		825633	10
11	1100	DIETARY	203179	1306624	1509803	-167359	1342444		1342444	11
12	1200	CAFETERIA				167359	167359	-90364	76995	12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	1143653	192564	1336217		1336217		1336217	14
15	1500	CENTRAL SERVICES & SUPPLY								15
16	1600	PHARMACY								16
17	1700	MEDICAL RECORDS & LIBRARY	340336	250170	590506		590506		590506	17
18	1800	SOCIAL SERVICE								18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A	182268	26242	208510	-208510				23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	12293707	1545069	13838776	616754	14455530		14455530	25
		ANCILLARY SERVICE COST CENTERS								
41	4100	RADIOLOGY-DIAGNOSTIC		44760	44760	554	45314		45314	41
44	4400	LABORATORY		886012	886012	35889	921901		921901	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	5000	PHYSICAL THERAPY	51886	3119	55005	2149	57154		57154	50
54	5400	ELECTROENCEPHALOGRAPHY		3440	3440	-3440				54
56	5600	DRUGS CHARGED TO PATIENTS		1632401	1632401	50421	1682822		1682822	56
59	3550	ADOLSCENT THERAPY								59
59.01	3950	ECT	326815	140965	467780	15988	483768		483768	59.01
59.02	3951	CHEMICAL DEPENDENCY								59.02
		OUTPATIENT SERVICE COST CENTERS								
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63	4950	PARTIAL HOSPITALIZATION	2274349	231070	2505419	205647	2711066		2711066	63
63.50	6310	RHC								63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
95		SUBTOTALS	22198661	26576718	48775379	-7452	48767927	-1158229	47609698	95
		NONREIMBURSABLE COST CENTERS								
97	9700	RESEARCH	876586	630413	1506999	7452	1514451	49248	1563699	97
98	9800	PHYSICIANS' PRIVATE OFFICES	5176152	971127	6147279		6147279	-835760	5311519	98
99	9900	NONPAID WORKERS	66863	5906	72769		72769		72769	99
100	7950	GUEST MEALS								100
100.01	7951	ADOLESCENT SCHOOL								100.01
100.02	7952	MARKETING								100.02
100.03	7953	OTHER NONREIMBURSEABLE								100.03
101		TOTAL	28318262	28184164	56502426		56502426	-1944741	54557685	101

RECLASSIFICATIONS — WORKSHEET A-6 — PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE: COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	EEG	A	ADULTS & PEDIATRICS	25		3440	1
2							2
3	BUILDING RENT EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3		119888	3
4		B					4
5							5
6	RENTAL EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		109735	6
7		C					7
8		C					8
9		C					9
10							10
11	RESIDENTS	D	ADULTS & PEDIATRICS	25	182268	26242	11
12							12
13	CAFETERIA	E	CAFETERIA	12	22522	144837	13
14							14
15	PFS	F	ADULTS & PEDIATRICS	25		462910	15
16		F	RADIOLOGY-DIAGNOSTIC	41		554	16
17		F	LABORATORY	44		35889	17
18		F	PHYSICAL THERAPY	50		2149	18
19		F	DRUGS CHARGED TO PATIENTS	56		50421	19
20		F	ECT	59.01		20872	20
21		F	PARTIAL HOSPITALIZATION	63		205647	21
22		F	RESEARCH	97		7452	22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				204790	1190036	36

RECLASSIFICATIONS WORKSHEET A-6
PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	EEG	A	ELECTROENCEPHALOGRAPHY	54		3440		1
2								2
3	BUILDING RENT EXPENSE	B	EMPLOYEE BENEFITS	5		26240	9	3
4		B	ADMINISTRATIVE & GENERAL	6		93648		4
5								5
6	RENTAL EXPENSE	C	ADMINISTRATIVE & GENERAL	6		2857	9	6
7		C	OPERATION OF PLANT	8		43888		7
8		C	ADULTS & PEDIATRICS	25		58106		8
9		C	ECT	59.01		4884		9
10								10
11	RESIDENTS	D	I&R SERVICES-OTHER PRGM COSTS	23	182268	26242		11
12								12
13	CAFETERIA	E	DIETARY	11	22522	144837		13
14								14
15	PFS	F	ADMINISTRATIVE & GENERAL	6		785894		15
16		F						16
17		F						17
18		F						18
19		F						19
20		F						20
21		F						21
22		F						22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				204790	1190036		36

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	1400000					1400000		1
2	LAND IMPROVEMENTS	426000	198000		198000		624000		2
3	BUILDINGS AND FIXTURES	25606000	109000		109000	14000	25701000		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	877000					877000		5
6	MOVABLE EQUIPMENT	4747000	74000		74000	54000	4767000		6
7	SUBTOTAL	33056000	381000		381000	68000	33369000		7
8	RECONCILING ITEMS								8
9	TOTAL	33056000	381000		381000	68000	33369000		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	COMPUTATION OF RATIOS: CAPITALIZED LEASES	COMPUTATION OF RATIOS: GROSS ASSETS FOR RATIO	COMPUTATION OF RATIOS: RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	ALLOCATION OF OTHER CAPITAL: TAXES	ALLOCATION OF OTHER CAPITAL: OTHER CAPITAL-RELATED COSTS	ALLOCATION OF OTHER CAPITAL: TOTAL	
		1	2	3	4	5	6	7	8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT				.000000					3
4	NEW CAP REL COSTS-MVBLE EQUIP				.000000					4
5	TOTAL				.000000					5

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	2008916	665990	301122				2976028	3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	TOTAL	2008916	665990	301122				2976028	5

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 COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	1234659						1234659	3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	TOTAL	1234659						1234659	5

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED — COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES	B	-60079	ADMINISTRATIVE & GENERAL	6		7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2					12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	930637				14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-90364	CAFETERIA	12		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS						20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES						22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4					36
37	OTHER INCOME	B	-85647	ADMINISTRATIVE & GENERAL	6		37
37.01	BAD DEBTS	A	-1481117	ADMINISTRATIVE & GENERAL	6		37.01
37.02	RESEARCH HBP	A	-148856	PHYSICIANS' PRIVATE OFFICES	98		37.02
37.03	GROUP PRACTICE HBP	A	-792347	PHYSICIANS' PRIVATE OFFICES	98		37.03
38	BUSINESS DEVELOPMENT/MARKETING	A	-253679	ADMINISTRATIVE & GENERAL	6		38
39	PHYSICIAN GUARANTEE FORGIVENESS	A	-218784	ADMINISTRATIVE & GENERAL	6		39
40	OTHER DISCOUNTS EARNED	B	-2128	ADMINISTRATIVE & GENERAL	6		40
41	SCHOOL REIMBURSEMENT	A	-408359	ADMINISTRATIVE & GENERAL	6		41
41.01	INTEREST EXPENSE-CAPITAL	A	665990	NEW CAP REL COSTS-BLDG & FIXT	3	10	41.01
42	INTEREST EXPENSE-NON CAPITAL	A	40826	ADMINISTRATIVE & GENERAL	6		42
43	REAL ESTATE TAXES	A	-33812	ADMINISTRATIVE & GENERAL	6		43
44	CONTRIBUTIONS	A	-7022	ADMINISTRATIVE & GENERAL	6		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL		-1944741				50

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

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	6	ADMINISTRATIVE & GENERAL	ABNH NON CAPITAL	3957557	4079480	-121923		1
2	3	NEW CAP REL COSTS-BLDG & FIXT	ABNH CAPITAL	594489		594489	9	2
3	6	ADMINISTRATIVE & GENERAL	EXECUTIVE SALARIES	677219	677219			3
4	3	NEW CAP REL COSTS-BLDG & FIXT	SALT CREEK CAPITAL	42377	93648	-51271	9	4
4.01	8	OPERATION OF PLANT	SALT CREEK NON CAPITAL	44133		44133		4.01
4.02	5	EMPLOYEE BENEFITS	EXECUTIVE BENEFITS	187751	187751			4.02
4.03	3	NEW CAP REL COSTS-BLDG & FIXT	LOSS ON REFINANCING	301122		301122	11	4.03
4.04	97	RESEARCH	ABMP	186784	137536	49248		4.04
4.05	98	PHYSICIANS' PRIVATE OFFICES	ABMP	370791	265348	105443		4.05
4.06	3	NEW CAP REL COSTS-BLDG & FIXT	ABMP CAPITAL	27656	26240	1416	9	4.06
4.07	8	OPERATION OF PLANT	ABMP NON CAPITAL	7980		7980		4.07
5		TOTALS		6397859	5467222	930637		5

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

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

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

			RELATED ORGANIZATION(S) AND/OR HOME OFFICE				
	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1	B	ALEXIAN BROS HEALTH	100.00				1
2							2
3							3
4							4
5							5

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	PERCENT OF UNADJUSTED RCE LIMIT
	1	2	3	4	5	6	7	8	9
2	6	ADMINISTRATIVE & GENERAL ADMINISTRATION	121903		121903	154100	2080	154100	7705
101		TOTAL	121903		121903		2080	154100	7705

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT
10	11	12	13	14	15	16	17	18
2 6	ADMINISTRATIVE & GENERAL ADMINISTRATION					154100		
101	TOTAL					154100		

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	2976028	2976028							3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS	4617328		4617328						5
6	ADMINISTRATIVE & GENERAL	13830734	916917	814473	15562124	15562124				6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	1656258	13960	20396	1690614	674680	2365294			8
9	LAUNDRY & LINEN SERVICE		6197		6197	2473	7167	15837		9
10	HOUSEKEEPING	825633	3484	9409	838526	334634	4030		1177190	10
11	DIETARY	1342444	39097	29719	1411260	563197	45218		22611	11
12	CAFETERIA	76995	63206	3705	143906	57429	73100		36554	12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	1336217		188137	1524354	608330				14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	590506	24927	55987	671420	267946	28829		14416	17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	14455530	1395999	2052356	17903885	7144984	1614525	15837	807360	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC	45314			45314	18084				41
44	LABORATORY	921901			921901	367907				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
50	PHYSICAL THERAPY	57154		8536	65690	26215				50
54	ELECTROENCEPHALOGRAPHY									54
56	DRUGS CHARGED TO PATIENTS	1682822	10640		1693462	675817	12305		6153	56
59	ADOLSCENT THERAPY									59
59.01	ECT	483768	14404	53763	551935	220263	16659		8331	59.01
59.02	CHEMICAL DEPENDENCY									59.02
	OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINCT									62
63	PARTIAL HOSPITALIZATION	2711066	129732	374142	3214940	1282999	150040		75029	63
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	47609698	2618563	3610623	46245528	12244958	1951873	15837	970454	95
	NONREIMBURSABLE COST CENTERS									
97	RESEARCH	1563699	4817	144203	1712719	683502	5571		2786	97
98	PHYSICIANS' PRIVATE OFFICES	5311519	352648	851503	6515670	2600234	407850		203950	98
99	NONPAID WORKERS	72769		10999	83768	33430				99
100	GUEST MEALS									100
100.01	ADOLESCENT SCHOOL									100.01
100.02	MARKETING									100.02
100.03	OTHER NONREIMBURSEABLE									100.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	54557685	2976028	4617328	54557685	15562124	2365294	15837	1177190	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		11	12	14	17	25	26	27	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE								9
10	HOUSEKEEPING								10
11	DIETARY	2042286							11
12	CAFETERIA		310989						12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION			2132684					14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY		7003		989614				17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES A								22
23	I&R SERVICES-OTHER PRGM COSTS A								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	2042286	191948	1759673	587930	32068428		32068428	25
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC				705	64103		64103	41
44	LABORATORY				45625	1335433		1335433	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	PHYSICAL THERAPY		459		3291	95655		95655	50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS				64098	2451835		2451835	56
59	ADOLSCENT THERAPY								59
59.01	ECT		4312		26534	828034		828034	59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINCT								62
63	PARTIAL HOSPITALIZATION		40689	373011	261431	5398139		5398139	63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	2042286	244411	2132684	989614	42241627		42241627	95
	NONREIMBURSABLE COST CENTERS								
97	RESEARCH		7760			2412338		2412338	97
98	PHYSICIANS' PRIVATE OFFICES		57711			9785415		9785415	98
99	NONPAID WORKERS		1107			118305		118305	99
100	GUEST MEALS								100
100.01	ADOLESCENT SCHOOL								100.01
100.02	MARKETING								100.02
100.03	OTHER NONREIMBURSEABLE								100.03
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	2042286	310989	2132684	989614	54557685		54557685	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	CAP REL COST TO BE ALLOC 4A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL		916917	916917	916917					6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		13960	13960	39751	53711				8
9	LAUNDRY & LINEN SERVICE		6197	6197	146	163	6506			9
10	HOUSEKEEPING		3484	3484	19716	92		23292		10
11	DIETARY		39097	39097	33183	1027		447	73754	11
12	CAFETERIA		63206	63206	3384	1660		723		12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION				35842					14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		24927	24927	15787	655		285		17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		1395999	1395999	420988	36662	6506	15975	73754	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC				1065					41
44	LABORATORY				21677					44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
50	PHYSICAL THERAPY				1545					50
54	ELECTROENCEPHALOGRAPHY									54
56	DRUGS CHARGED TO PATIENTS		10640	10640	39818	279		122		56
59	ADOLSCENT THERAPY									59
59.01	ECT		14404	14404	12978	378		165		59.01
59.02	CHEMICAL DEPENDENCY									59.02
	OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINCT									62
63	PARTIAL HOSPITALIZATION		129732	129732	75593	3407		1485		63
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS		2618563	2618563	721473	44323	6506	19202	73754	95
	NONREIMBURSABLE COST CENTERS									
97	RESEARCH		4817	4817	40271	127		55		97
98	PHYSICIANS' PRIVATE OFFICES		352648	352648	153203	9261		4035		98
99	NONPAID WORKERS				1970					99
100	GUEST MEALS									100
100.01	ADOLESCENT SCHOOL									100.01
100.02	MARKETING									100.02
100.03	OTHER NONREIMBURSEABLE									100.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		2976028	2976028	916917	53711	6506	23292	73754	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B
PART III

	COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		12	14	17	25	26	27	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT							3
4	NEW CAP REL COSTS-MVBLE EQUIP							4
5	EMPLOYEE BENEFITS							5
6	ADMINISTRATIVE & GENERAL							6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT							8
9	LAUNDRY & LINEN SERVICE							9
10	HOUSEKEEPING							10
11	DIETARY							11
12	CAFETERIA	68973						12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION		35842					14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY	1553		43207				17
18	SOCIAL SERVICE							18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A							22
23	I&R SERVICES-OTHER PRGM COSTS A							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	42571	29573	25683	2047711		2047711	25
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC			31	1096		1096	41
44	LABORATORY			1990	23667		23667	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
50	PHYSICAL THERAPY	102		144	1791		1791	50
54	ELECTROENCEPHALOGRAPHY							54
56	DRUGS CHARGED TO PATIENTS			2796	53655		53655	56
59	ADOLSCENT THERAPY							59
59.01	ECT	956		1158	30039		30039	59.01
59.02	CHEMICAL DEPENDENCY							59.02
	OUTPATIENT SERVICE COST CENTERS							
62	OBSERVATION BEDS (NON-DISTINCT							62
63	PARTIAL HOSPITALIZATION	9024	6269	11405	236915		236915	63
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
95	SUBTOTALS	54206	35842	43207	2394874		2394874	95
	NONREIMBURSABLE COST CENTERS							
97	RESEARCH	1721			46991		46991	97
98	PHYSICIANS' PRIVATE OFFICES	12800			531947		531947	98
99	NONPAID WORKERS	246			2216		2216	99
100	GUEST MEALS							100
100.01	ADOLESCENT SCHOOL							100.01
100.02	MARKETING							100.02
100.03	OTHER NONREIMBURSEABLE							100.03
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	68973	35842	43207	2976028		2976028	103

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT SQUARE FEET	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT	127270							1
2	OLD CAP REL COSTS-MVBLE EQUIP		127270						2
3	NEW CAP REL COSTS-BLDG & FIXT			127270					3
4	NEW CAP REL COSTS-MVBLE EQUIP				127270				4
5	EMPLOYEE BENEFITS					28068026			5
6	ADMINISTRATIVE & GENERAL	39212	39212	39212	39212	4951051	-15562124	38995561	6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	597	597	597	597	123986		1690614	8
9	LAUNDRY & LINEN SERVICE	265	265	265	265			6197	9
10	HOUSEKEEPING	149	149	149	149	57195		838526	10
11	DIETARY	1672	1672	1672	1672	180657		1411260	11
12	CAFETERIA	2703	2703	2703	2703	22522		143906	12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION					1143653		1524354	14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	1066	1066	1066	1066	340336		671420	17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	59700	59700	59700	59700	12475975		17903885	25
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC							45314	41
44	LABORATORY							921901	44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY					51886		65690	50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS	455	455	455	455			1693462	56
59	ADOLSCENT THERAPY								59
59.01	ECT	616	616	616	616	326815		551935	59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION	5548	5548	5548	5548	2274349		3214940	63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	111983	111983	111983	111983	21948425	-15562124	30683404	95
	NONREIMBURSABLE COST CENTERS								
97	RESEARCH	206	206	206	206	876586		1712719	97
98	PHYSICIANS' PRIVATE OFFICES	15081	15081	15081	15081	5176152		6515670	98
99	NONPAID WORKERS					66863		83768	99
100	GUEST MEALS								100
100.01	ADOLESCENT SCHOOL								100.01
100.02	MARKETING								100.02
100.03	OTHER NONREIMBURSEABLE								100.03
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I			2976028		4617328		15562124	103
104	UNIT COST MULT-WS B PT I								104
104	UNIT COST MULT-WS B PT I			23.383578		.164505		.399074	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III							916917	107
108	UNIT COST MULT-WS B PT III								108
108	UNIT COST MULT-WS B PT III							.023513	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA FULL TIME EQUIV'S 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 17	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	87461							8
9	LAUNDRY & LINEN SERVICE	265	100						9
10	HOUSEKEEPING	149		87047					10
11	DIETARY	1672		1672	137799				11
12	CAFETERIA	2703		2703		34547			12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION						25843		14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	1066		1066		778		92841007	17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	59700	100	59700	137799	21323	21323	55156072	25
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC							66121	41
44	LABORATORY							4280409	44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY					51		308778	50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS	455		455				6013509	56
59	ADOLSCENT THERAPY								59
59.01	ECT	616		616		479		2489340	59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION	5548		5548		4520	4520	24526778	63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	72174	100	71760	137799	27151	25843	92841007	95
	NONREIMBURSABLE COST CENTERS								
97	RESEARCH	206		206		862			97
98	PHYSICIANS' PRIVATE OFFICES	15081		15081		6411			98
99	NONPAID WORKERS					123			99
100	GUEST MEALS								100
100.01	ADOLESCENT SCHOOL								100.01
100.02	MARKETING								100.02
100.03	OTHER NONREIMBURSEABLE								100.03
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	2365294	15837	1177190	2042286	310989	2132684	989614	103
104	UNIT COST MULT-WS B PT I	27.043985		13.523614		9.001910		.010659	104
104	UNIT COST MULT-WS B PT I		158.370000		14.820761		82.524629		104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III	53711	6506	23292	73754	68973	35842	43207	107
108	UNIT COST MULT-WS B PT III	.614114		.267580		1.996498		.000465	108
108	UNIT COST MULT-WS B PT III		65.060000		.535229		1.386913		108

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	32068428		32068428		32068428	25
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY-DIAGNOSTIC	64103		64103		64103	41
44	LABORATORY	1335433		1335433		1335433	44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
50	PHYSICAL THERAPY	95655		95655		95655	50
54	ELECTROENCEPHALOGRAPHY						54
56	DRUGS CHARGED TO PATIENTS	2451835		2451835		2451835	56
59	ADOLSCENT THERAPY						59
59.01	ECT	828034		828034		828034	59.01
59.02	CHEMICAL DEPENDENCY						59.02
	OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTI						62
63	PARTIAL HOSPITALIZATION	5398139		5398139		5398139	63
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	42241627		42241627		42241627	101
102	LESS OBSERVATION BEDS						102
103	TOTAL	42241627		42241627		42241627	103

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT	CHARGES OUTPATIENT	CHARGES TOTAL	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	55156072		55156072				25
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	66121		66121	.969480	.969480	.969480	41
44	LABORATORY	4057564	222845	4280409	.311987	.311987	.311987	44
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
50	PHYSICAL THERAPY	308778		308778	.309786	.309786	.309786	50
54	ELECTROENCEPHALOGRAPHY							54
56	DRUGS CHARGED TO PATIENTS	6013509		6013509	.407721	.407721	.407721	56
59	ADOLSCENT THERAPY							59
59.01	ECT	1403590	1085750	2489340	.332632	.332632	.332632	59.01
59.02	CHEMICAL DEPENDENCY							59.02
	OUTPATIENT SERVICE COST CENTERS							
62	OBSERVATION BEDS (NON-DISTI							62
63	PARTIAL HOSPITALIZATION		24526778	24526778	.220092	.220092	.220092	63
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	67005634	25835373	92841007				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	67005634	25835373	92841007				103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL: CAPITAL RELATED COST (1)	OLD CAPITAL: SWING-BED ADJUSTMENT (2)	OLD CAPITAL: REDUCED CAPITAL RELATED COST (3)	NEW CAPITAL: CAPITAL RELATED COST (4)	NEW CAPITAL: SWING-BED ADJUSTMENT (5)	NEW CAPITAL: REDUCED CAPITAL RELATED COST (6)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				2047711		2047711	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL				2047711		2047711	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS (7)	INPATIENT PROGRAM DAYS (8)	OLD CAPITAL: PER DIEM (9)	OLD CAPITAL: INPATIENT PROGRAM CAPITAL COST (10)	NEW CAPITAL: PER DIEM (11)	NEW CAPITAL: INPATIENT PROGRAM CAPITAL COST (12)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	45933	18149			44.58	809082	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL	45933	18149				809082	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB III	[XX] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SUB IV	[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II			

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		1096	66121	49263			.016576	817	41
44	LABORATORY		23667	4280409	1509606			.005529	8347	44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
50	PHYSICAL THERAPY		1791	308778	265555			.005800	1540	50
54	ELECTROENCEPHALOGRAPHY									54
56	DRUGS CHARGED TO PATIENTS		53655	6013509	3229692			.008922	28815	56
59	ADOLSCENT THERAPY									59
59.01	ECT		30039	2489340	683250			.012067	8245	59.01
59.02	CHEMICAL DEPENDENCY									59.02
	OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINC									62
63	PARTIAL HOSPITALIZATION		236915	24526778				.009659		63
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		347163	37684935	5737366				47764	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					45933		18149		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					45933		18149		101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST				TOTAL COSTS	
		1	1.01	2	N/A 2.01	N/A 2.02	N/A 2.03	3	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY								50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS								56
59	ADOLSCENT THERAPY								59
59.01	ECT								59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION								63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL								101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF			
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC		66121			49263			41
44	LABORATORY		4280409			1509606		2404	44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY		308778			265555			50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS		6013509			3229692			56
59	ADOLSCENT THERAPY								59
59.01	ECT		2489340			683250		511500	59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION		24526778					1364930	63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		37684935			5737366		1878834	101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF			
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
50	PHYSICAL THERAPY						50
54	ELECTROENCEPHALOGRAPHY						54
56	DRUGS CHARGED TO PATIENTS						56
59	ADOLSCENT THERAPY						59
59.01	ECT						59.01
59.02	CHEMICAL DEPENDENCY						59.02
	OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTINC						62
63	PARTIAL HOSPITALIZATION						63
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	TOTAL						101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST — WORKSHEET D, PARTS V & VI

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-4031)	[ ]	SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES — OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	.969480	.969480	.969480				41
44	LABORATORY	.311987	.311987	.311987				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
50	PHYSICAL THERAPY	.309786	.309786	.309786				50
54	ELECTROENCEPHALOGRAPHY							54
56	DRUGS CHARGED TO PATIENTS	.407721	.407721	.407721				56
59	ADOLSCENT THERAPY							59
59.01	ECT	.332632	.332632	.332632				59.01
59.02	CHEMICAL DEPENDENCY							59.02
	OUTPATIENT SERVICE COST CENTERS							
62	OBSERVATION BEDS (NON-DISTINCT							62
63	PARTIAL HOSPITALIZATION	.220092	.220092	.220092				63
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65.01	AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.							65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.407721	1
2	PROGRAM VACCINE CHARGES		2
2.01	PROGRAM VACCINE CHARGES		2.01
3	PROGRAM COSTS		3
3.01	PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST — WORKSHEET D, PARTS V & VI

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-4031)	[ ]	SNF	
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF	
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF	
			[ ]	SUB III	[ ]	S/B-NF	
			[ ]	SUB IV	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	PROGRAM CHARGES: ALL OTHER (1) (SEE INSTRU.) 5	PPS SERVICES (SEE INSTRU.) 5.01	ALL OTHER (SEE INSTRU.) 5.02	PPS SERVICES (SEE INSTRU.) 5.03	PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST: OUTPATIENT AMBULATORY SURGICAL CENTER 6	OUTPATIENT RADIOLOGY 7	OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC									41
44	LABORATORY		2404							44
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
50	PHYSICAL THERAPY									50
54	ELECTROENCEPHALOGRAPHY									54
56	DRUGS CHARGED TO PATIENTS									56
59	ADOLSCENT THERAPY									59
59.01	ECT		511500							59.01
59.02	CHEMICAL DEPENDENCY									59.02
	OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINCT									62
63	PARTIAL HOSPITALIZATION		1364930							63
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65.01	AMBULANCE SERVICES (2ND PERIOD									65.01
65.02	AMBULANCE SERVICES (3RD PERIOD									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL		1878834							101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES		1878834							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-4031)	[ ] SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ] NF
BOXES	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ] S/B-SNF
			[ ]	SUB III	[ ] S/B-NF
			[ ]	SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY		750						44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
50	PHYSICAL THERAPY								50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS								56
59	ADOLSCENT THERAPY								59
59.01	ECT		170141						59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINCT								62
63	PARTIAL HOSPITALIZATION		300410						63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65.01	AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL		471301						101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES		471301						104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL: CAPITAL RELATED COST (1)	OLD CAPITAL: SWING-BED ADJUSTMENT (2)	OLD CAPITAL: REDUCED CAPITAL RELATED COST (3)	NEW CAPITAL: CAPITAL RELATED COST (4)	NEW CAPITAL: SWING-BED ADJUSTMENT (5)	NEW CAPITAL: REDUCED CAPITAL RELATED COST (6)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				2047711		2047711	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL				2047711		2047711	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS (7)	INPATIENT PROGRAM DAYS (8)	OLD CAPITAL: PER DIEM (9)	OLD CAPITAL: INPATIENT PROGRAM CAPITAL COST (10)	NEW CAPITAL: PER DIEM (11)	NEW CAPITAL: INPATIENT PROGRAM CAPITAL COST (12)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	45933	4410			44.58	196598	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL	45933	4410				196598	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX] HOSPITAL (14-4031)	[ ] SUB III	[ ] PPS
	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SUB IV	[ ] TEFRA
	[XX] TITLE XIX	[ ] SUB II	[XX] OTHER	

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		1096	66121				.016576		41
44	LABORATORY		23667	4280409				.005529		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
50	PHYSICAL THERAPY		1791	308778				.005800		50
54	ELECTROENCEPHALOGRAPHY									54
56	DRUGS CHARGED TO PATIENTS		53655	6013509				.008922		56
59	ADOLSCENT THERAPY									59
59.01	ECT		30039	2489340				.012067		59.01
59.02	CHEMICAL DEPENDENCY									59.02
	OUTPATIENT SERVICE COST CENTERS									
62	OBSERVATION BEDS (NON-DISTINC									62
63	PARTIAL HOSPITALIZATION		236915	24526778				.009659		63
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		347163	37684935						101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					45933		4410		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					45933		4410		101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER	
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		1	1.01	2	2.01	2.02	2.03	3	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY								50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS								56
59	ADOLSCENT THERAPY								59
59.01	ECT								59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION								63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL								101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER	
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC		66121						41
44	LABORATORY		4280409						44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
50	PHYSICAL THERAPY		308778						50
54	ELECTROENCEPHALOGRAPHY								54
56	DRUGS CHARGED TO PATIENTS		6013509						56
59	ADOLSCENT THERAPY								59
59.01	ECT		2489340						59.01
59.02	CHEMICAL DEPENDENCY								59.02
	OUTPATIENT SERVICE COST CENTERS								
62	OBSERVATION BEDS (NON-DISTINC								62
63	PARTIAL HOSPITALIZATION		24526778						63
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		37684935						101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-4031)	[ ]	SUB IV	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ] OTHER
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
50	PHYSICAL THERAPY						50
54	ELECTROENCEPHALOGRAPHY						54
56	DRUGS CHARGED TO PATIENTS						56
59	ADOLSCENT THERAPY						59
59.01	ECT						59.01
59.02	CHEMICAL DEPENDENCY						59.02
	OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTINC						62
63	PARTIAL HOSPITALIZATION						63
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	TOTAL						101

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (PPS) (14-4031) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	45933						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	45933						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	45933						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							6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	18149						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							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							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							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	SNF	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	32068428						21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26	TOTAL SWING-BED COST							26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	32068428						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.787777						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	390.52						33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	32068428						37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	698.16					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	12670906					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	12670906					41

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

		HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	2145085					48
49	TOTAL PROGRAM INPATIENT COSTS	14815991					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	809082					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	47764					51
52	TOTAL PROGRAM EXCLUDABLE COST	856846					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	13959145					53

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1, PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

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

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

	HOSPITAL (PPS) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS		83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	698.16	84
85 OBSERVATION BED COST		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		32068428				86
87 NEW CAPITAL-RELATED COST	2047711	32068428	.063854			87
88 NON PHYSICIAN ANESTHETIST		32068428				88
89 MEDICAL EDUCATION		32068428				89

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

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	NF	
	INPATIENT DAYS	1	1	1	1	1	1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	45933						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	45933						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	45933						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							6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4410						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							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							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							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	NF	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	32068428						21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26	TOTAL SWING-BED COST							26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	32068428						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	17937595						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.787777						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	390.52						33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	32068428						37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	698.16					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3078886					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	3078886					41

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

		HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49	TOTAL PROGRAM INPATIENT COSTS	3078886					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	196598					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST	196598					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES	395					54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1, PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY — NF

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

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

	HOSPITAL (OTHER) (14-4031)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS						83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	698.16					84
85 OBSERVATION BED COST						85

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-4031)	[ ] SNF	[XX] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[ ] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		22248196		25
	ANCILLARY SERVICE COST CENTERS				
41	RADIOLOGY-DIAGNOSTIC	.969480	49263	47759	41
44	LABORATORY	.311987	1509606	470977	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
50	PHYSICAL THERAPY	.309786	265555	82265	50
54	ELECTROENCEPHALOGRAPHY				54
56	DRUGS CHARGED TO PATIENTS	.407721	3229692	1316813	56
59	ADOLSCENT THERAPY				59
59.01	ECT	.332632	683250	227271	59.01
59.02	CHEMICAL DEPENDENCY				59.02
	OUTPATIENT SERVICE COST CENTERS				
62	OBSERVATION BEDS (NON-DISTINCT				62
	OTHER REIMBURSABLE COST CENTERS				
63	PARTIAL HOSPITALIZATION	.220092			63
63.50	RHC				63.50
63.60	FQHC				63.60
101	TOTAL		5737366	2145085	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		5737366		103

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-4031)	[ ] SNF	[ ] PPS	
[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA	
[XX] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[XX] OTHER	
	[ ] SUB III	[ ] S/B-NF		
	[ ] SUB IV	[ ] ICF/MR		

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
41	RADIOLOGY-DIAGNOSTIC	.969480			41
44	LABORATORY	.311987			44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
50	PHYSICAL THERAPY	.309786			50
54	ELECTROENCEPHALOGRAPHY				54
56	DRUGS CHARGED TO PATIENTS	.407721			56
59	ADOLSCENT THERAPY				59
59.01	ECT	.332632			59.01
59.02	CHEMICAL DEPENDENCY				59.02
	OUTPATIENT SERVICE COST CENTERS				
62	OBSERVATION BEDS (NON-DISTINCT				62
	OTHER REIMBURSABLE COST CENTERS				
63	PARTIAL HOSPITALIZATION	.220092			63
63.50	RHC				63.50
63.60	FQHC				63.60
101	TOTAL				101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES				103

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
	DRG AMOUNT						
1	OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03	PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04	PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05	PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06	ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07	PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08	SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997						2.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
3	BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01	NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06	ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]						3.06
3.07	SUM OF LINES 3.04-3.06	0.00	0.00				3.07
3.08	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13	FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14	CURRENT YEAR ALLOWABLE FTE						3.14
3.15	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
3.17	SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	RES. IN INIT YRS 0.00					3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO						3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO						3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19						3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1						3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1						3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23	0		0			3.24
	DISPROPORTIONATE SHARE ADJUSTMENT						
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS						4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS						4.01
4.02	SUM OF 4 AND 4.01						4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						4.04
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317						5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317						5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						5.05
5.06	TOTAL ADDITIONAL PAYMENT						5.06
6	SUBTOTAL						6
7	HOSPITAL SPECIFIC PAYMENTS						7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)						7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS						8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL						9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL						10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT						11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE						11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES						11.02
12	NET ORGAN ACQUISITION COST						12
13	COST OF TEACHING PHYSICIANS						13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS						14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						15
16	TOTAL						16
17	PRIMARY PAYER PAYMENTS						17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES						18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES						19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES						20
21	REIMBURSABLE BAD DEBTS						21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS						21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						21.02
22	SUBTOTAL						22

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						23
24	OTHER ADJUSTMENTS						24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						25
26	AMOUNT DUE PROVIDER						26
27	SEQUESTRATION ADJUSTMENT						27
28	INTERIM PAYMENTS						28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						28.01
29	BALANCE DUE PROVIDER (PROGRAM)						29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						30
	TO BE COMPLETED BY INTERMEDIARY						
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01						50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01						51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)						52
53	CAPITAL OUTLIER RECONILIATION AMOUNT (SEE INSTRUCTIONS)						53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)						55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)						56

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-4031) 1	HOSPITAL (14-4031) 1.01	HOSPITAL (14-4031) 1.02	
1	MEDICAL AND OTHER SERVICES				1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	471301			1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	688959			1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST				5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES				17
17.01	TOTAL PPS PAYMENTS	688959			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-4031) 1	HOSPITAL (14-4031) 1.01	HOSPITAL (14-4031) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES AND COINSURANCE				18
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	142565			18.01
19	SUBTOTAL	546394			19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL	546394			23
24	PRIMARY PAYER PAYMENTS	2217			24
25	SUBTOTAL	544177			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	27193			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	19035			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	21645			27.02
28	SUBTOTAL	563212			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL	563212			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	537877			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	25335			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-4031) OCTOBER 1, 1997 PRIOR TO 1	HOSPITAL (14-4031) OCTOBER 1, 1997 ON OR AFTER 1.01	
1	STANDARD OVERHEAD AMOUNTS (ASC FEES)			1
2	DEDUCTIBLES			2
3	SUBTOTAL			3
4	80 PERCENT OF LINE 3			4
5	ASC PORTION OF BLEND			5
6	OUTPATIENT ASC COST			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	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)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	HOSPITAL SPECIFIC PORTION OF BLEND			17
18	ASC BLENDED AMOUNT			18
19	LESSER OF LINES 16 OR 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	ASC PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-4031) OCTOBER 1, 1997 PRIOR TO ON OR AFTER 1 1.01	
1	PREVAILING CHARGES		1
2	62 PERCENT OF LINE 1		2
3	DEDUCTIBLES		3
4	SUBTOTAL		4
5	BLENDED CHARGE PROPORTION		5
6	COST OF OUTPATIENT RADIOLOGY		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES		7
	CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		9
10	RATIO OF LINE 8 TO LINE 9		10
11	TOTAL CUSTOMARY CHARGES		11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14	LESSER OF COST OR CHARGES		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE		15
16	TOTAL		16
17	COST PROPORTION		17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT		18
19	LESSER OF LINE 16 OR LINE 18		19
20	PART B DEDUCTIBLES AND COINSURANCE		20
21	RADIOLOGY PAYMENT AMOUNT		21

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (14-4031) OCTOBER 1, 1997 PRIOR TO ON OR AFTER 1 1.01	
1	PREVAILING CHARGES		1
2	42 PERCENT OF LINE 1		2
3	DEDUCTIBLES		3
4	SUBTOTAL		4
5	BLENDED CHARGE PROPORTION		5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES		6
	COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES		7
	CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)		9
10	RATIO OF LINE 8 TO LINE 9		10
11	TOTAL CUSTOMARY CHARGES		11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14	LESSER OF COST OR CHARGES		14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE		15
16	TOTAL		16
17	COST PROPORTION		17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT		18
19	LESSER OF LINE 16 OR LINE 18		19
20	PART B DEDUCTIBLES AND COINSURANCE		20
21	DIAGNOSTIC PAYMENT AMOUNT		21

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

HOSPITAL (14-4031)

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				12906580		544177	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				97000		14100	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
		PROGRAM	.02					3.02
		TO	.03		NONE		NONE	3.03
		PROVIDER	.04					3.04
			.05					3.05
			.50			08/01/2007	20400	3.50
		PROVIDER	.51					3.51
		TO	.52		NONE			3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99				-20400	3.99
4	TOTAL INTERIM PAYMENTS				13003580		537877	4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
		TO	.02		NONE		NONE	5.02
		PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		TO	.51		NONE		NONE	5.51
		PROGRAM	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		58558		25335	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				13062138		563212	7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____ DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART I

MEDICARE PART A SERVICES - TEFRA

		HOSPITAL (14-4031)	SUB I	SUB II	SUB III	SUB IV	
1	INPATIENT HOSPITAL SERVICES						1
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)						1.01
1.02	NET FEDERAL PPS PAYMENTS (SEE INSTRUCTIONS)						1.02
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)						1.03
1.04	INPATIENT REHAB LIP PAYMENTS (SEE INSTRUCTIONS)						1.04
1.05	OUTLIER PAYMENTS						1.05
1.06	TOTAL PPS PAYMENTS						1.06
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT						1.07
	INPATIENT PSYCHIATRIC FACILITY (IPF)						
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, STOP-LOSS, ECT, AND TEACHING ADJUSTMENT)	13789802					1.08
1.09	NET IPF PPS OUTLIER PAYMENTS	21191					1.09
1.10	NET IPF PPS ECT PAYMENTS	259293					1.10
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004. (SEE INSTRUCTIONS)						1.11
1.12	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTR.)						1.12
1.13	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM'. (SEE INSTR.)						1.13
1.14	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM'. (SEE INSTR.)						1.14
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)						1.15
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	125.500000					1.16
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR						1.17
1.18	MEDICAL EDUCATION ADJUSTMENT						1.18
1.19	ADJUSTED NET IPF PPS PAYMENTS	14070286					1.19
1.20	STOP LESS PAYMENT FLOOR						1.20
1.21	ADJUSTED NET PAYMENT FLOOR						1.21
1.22	STOP LOSS ADJUSTMENT						1.22
1.23	TOTAL IPF PPS PAYMENTS	14070286					1.23
	INPATIENT REHABILITATION FACILITY (IRF)						
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INSTRUCTIONS)						1.35
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTR.)						1.36
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTEs IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INSTRUCTIONS)						1.37
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INSTRUCTIONS)						1.38
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT. (SEE INSTRUCTIONS)						1.39
1.40	AVERAGE DAILY CENSUS. (SEE INSTRUCTIONS)						1.40
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR						1.41
1.42	MEDICAL EDUCATION ADJUSTMENT						1.42
2	ORGAN ACQUISITION						2
3	COST OF TEACHING PHYSICIANS						3
4	SUBTOTAL	14070286					4
5	PRIMARY PAYER PAYMENTS	96642					5
6	SUBTOTAL	13973644					6
7	DEDUCTIBLES	656448					7
8	SUBTOTAL	13317196					8
9	COINSURANCE	410616					9
10	SUBTOTAL	12906580					10
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	222225					11
11.01	REDUCED REIMBURSABLE BAD DEBTS	155558					11.01
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	169207					11.02
12	SUBTOTAL	13062138					12
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						13

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART I

MEDICARE PART A SERVICES - TEFRA

		HOSPITAL (14-4031)	SUB I	SUB II	SUB III	SUB IV	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)						13.01
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						14
15	OTHER ADJUSTMENTS						15
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						16
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER	13062138					17
18	SEQUESTRATION ADJUSTMENT						18
19	INTERIM PAYMENTS	13003580					19
19.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						19.01
20	BALANCE DUE PROVIDER/PROGRAM	58558					20
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						21
	TO BE COMPLETED BY INTERMEDIARY						
50	ORIGINAL OUTLIER AMOUNT						50
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)						51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						52
53	OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)						53

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY PART III

[ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

		HOSPITAL (14-4031) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	3078886						1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	3078886						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	3078886						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES							11
12	INTERNS AND RESIDENTS SERVICE CHARGES							12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE							13
14	TEACHING PHYSICIANS							14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION							15
16	TOTAL REASONABLE CHARGES							16
	CUSTOMARY CHARGES							
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							18
19	RATIO OF LINE 17 TO LINE 18							19
20	TOTAL CUSTOMARY CHARGES							20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	3078886						22
23	COST OF COVERED SERVICES	3078886						23
	PROSPECTIVE PAYMENT AMOUNT							
24	OTHER THAN OUTLIER PAYMENTS							24
25	OUTLIER PAYMENTS							25
26	PROGRAM CAPITAL PAYMENTS							26
27	CAPITAL EXCEPTION PAYMENTS							27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS							28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS							29
30	SUBTOTAL	3078886						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31	3078886						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY — PART III

[ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

		HOSPITAL (14-4031) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST	3078886						34
35	SUBTOTAL							35
36	COINSURANCE							36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,							37
38	REIMBURSABLE BAD DEBTS							38
38.01	REDUCED REIMBURSABLE BAD DEBTS							38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							38.02
39	UTILIZATION REVIEW							39
40	SUBTOTAL							40
41	INPATIENT ROUTINE SERVICE COST							41
42	MEDICARE INPATIENT ROUTINE CHARGES							42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							44
45	RATIO OF LINE 43 TO LINE 44							45
46	TOTAL CUSTOMARY CHARGES							46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							49
50	OTHER ADJUSTMENTS							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL							52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER							55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM							58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							59

BALANCE SHEET — WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1562000				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	9238000				4
5	OTHER RECEIVABLES	421000				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	147000				7
8	PREPAID EXPENSES	186000				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	11554000				11
	FIXED ASSETS					
12	LAND	1400000				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	624000				13
13.01	ACCUMULATED DEPRECIATION	-331000				13.01
14	BUILDINGS	25701000				14
14.01	ACCUMULATED DEPRECIATION	-3383000				14.01
15	LEASEHOLD IMPROVEMENTS	187000				15
15.01	ACCUMULATED AMORTIZATION	-2000				15.01
16	FIXED EQUIPMENT	877000				16
16.01	ACCUMULATED DEPRECIATION	-503000				16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT	4769000				18
18.01	ACCUMULATED DEPRECIATION	-3342000				18.01
19	MINOR EQUIPMENT DEPRECIABLE	176000				19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	26173000				21
	OTHER ASSETS					
22	INVESTMENTS	4000000				22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	64000				25
26	TOTAL OTHER ASSETS	4064000				26
27	TOTAL ASSETS	41791000				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	496000				28
29	SALARIES, WAGES & FEES PAYABLE					29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME	2788000				32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	4880000				35
36	TOTAL CURRENT LIABILITIES	8164000				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE					38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES	2340000				41
42	TOTAL LONG TERM LIABILITIES	2340000				42
43	TOTAL LIABILITIES	10504000				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	31287000				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	31287000				51
52	TOTAL LIABILITIES AND FUND BALANCES	41791000				52

STATEMENT OF CHANGES IN FUND BALANCES — WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD	35449000				1
2	NET INCOME (LOSS)	-4162000				2
3	TOTAL	31287000				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	31287000				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	31287000				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES — WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	55156000		55156000	1
2	SUBPROVIDER I				2
4	SWING BED - SNF				4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	55156000		55156000	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	55156000		55156000	16
17	ANCILLARY SERVICES	12740000	34381000	47121000	17
18	OUTPATIENT SERVICES				18
18.50	RHC				18.50
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	67896000	34381000	102277000	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		56502426	26
27	ADD (SPECIFY)			27
28	INTEREST EXPENSE	1107000		28
29	IMMATERIAL VARIANCE			29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1107000	33
34	DEDUCT (SPECIFY)			34
35	IMMATERIAL VARIANCE	-426		35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS	-426		39
40	TOTAL OPERATING EXPENSES		57609000	40

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	102277000	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	52153000	2
3	NET PATIENT REVENUES	50124000	3
4	LESS - TOTAL OPERATING EXPENSES	57609000	4
5	NET INCOME FROM SERVICE TO PATIENTS	-7485000	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	33000	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	80000	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	86000	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	12000	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	CAPITATION REVENUE	737000	24
24.01	RESEARCH REVENUE	1392000	24.01
24.02	SCHOOL REVENUE	382000	24.02
24.03	ACCESS INTERCO REVENUE	326000	24.03
24.04	ECT PUBLIC AID	143000	24.04
24.05	RESTRICTED FUNDS	10000	24.05
24.06	AFTERCARE	40000	24.06
24.07	OTHER INCOME	82000	24.07
25	TOTAL OTHER INCOME	3323000	25
26	TOTAL	-4162000	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-4162000	31

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - COST METHOD — WORKSHEET L

		HOSPITAL 1	HOSPITAL 1.01	SUB I	SUB II	SUB III	
	PART I - FULLY PROSPECTIVE METHOD						
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS						1
	CAPITAL FEDERAL AMOUNT						
2	CAPITAL DRG OTHER THAN OUTLIER						2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997						3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997						3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [E,PT A,LN.3.17][E-3,PT VI,LN.18][x E-3,PT VI,LN.1]						4
4.01	NO. OF INTERNS & RESIDENTS	0.00	0.00				4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						4.02
4.03	INDIRECT MEDICAL EDUCATON ADJUSTMENT						4.03
	DISPROPORTIONATE SHARE ADJUSTMENT						
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS						5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I						5.01
5.02	SUM OF LINES 5 AND 5.01						5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT						5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS						6
	PART II - HOLD HARMLESS METHOD						
1	NEW CAPITAL						1
2	OLD CAPITAL						2
3	TOTAL CAPITAL						3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL						4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE						5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT						6
7	REDUCED OLD CAPITAL AMOUNT						7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL						8
9	SUBTOTAL						9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)						10
	PART III - PAYMENT UNDER REASONABLE COST						
1	PROGRAM INPATIENT ROUTINE CAPITAL COST						1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST						2
3	TOTAL INPATIENT PROGRAM CAPITAL						3
4	CAPITAL COST PAYMENT FACTOR						4
5	TOTAL INPATIENT PROGRAM CAPITAL COST						5
	PART IV - COMPUTATION OF EXCEPTION PAYMENTS						
1	PROGRAM INPATIENT CAPITAL COSTS						1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						2
3	NET PROGRAM INPATIENT CAPITAL COSTS						3
4	APPLICABLE EXCEPTION PERCENTAGE						4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS						5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES						6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES						7
8	CAPITAL MINIMUM PAYMENT LEVEL						8
9	CURRENT YEAR CAPITAL PAYMENTS						9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS						10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT						11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS						12
13	CURRENT YEAR EXCEPTION PAYMENT						13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD						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						17

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES A						22
23	I&R SERVICES-OTHER PRGM COSTS A						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
50	PHYSICAL THERAPY						50
54	ELECTROENCEPHALOGRAPHY						54
56	DRUGS CHARGED TO PATIENTS						56
59	ADOLSCENT THERAPY						59
59.01	ECT						59.01
59.02	CHEMICAL DEPENDENCY						59.02
	OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTINCT						62
63	PARTIAL HOSPITALIZATION						63
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
97	RESEARCH						97
98	PHYSICIANS' PRIVATE OFFICES						98
99	NONPAID WORKERS						99
00	GUEST MEALS						00
00.01	ADOLESCENT SCHOOL						00.01
00.02	MARKETING						00.02
00.03	OTHER NONREIMBURSEABLE						00.03
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

***** REPORT 97 ***** UTILIZATION STATISTICS ***** HOSPITAL

	COST CENTERS	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX INPATIENT	TITLE XIX OUTPATIENT	TITLE V INPATIENT	TITLE V OUTPATIENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	39.51		9.60				49.11	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
41	RADIOLOGY-DIAGNOSTIC	74.50						74.50	41
44	LABORATORY	35.27	0.06					35.33	44
50	PHYSICAL THERAPY	86.00						86.00	50
56	DRUGS CHARGED TO PATIENTS	53.71						53.71	56
59.01	ECT	27.45	20.55					48.00	59.01
63	PARTIAL HOSPITALIZATION		5.57					5.57	63
101	TOTAL CHARGES	6.18	2.02					8.20	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	2976028	5.45	-2976028	-10.92			3
4	NEW CAP REL COSTS-MVBLE EQUIP							4
5	EMPLOYEE BENEFITS	4617328	8.46	-4617328	-16.94			5
6	ADMINISTRATIVE & GENERAL	13830734	25.35	-13830734	-50.75			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	1656258	3.04	-1656258	-6.08			8
9	LAUNDRY & LINEN SERVICE							9
10	HOUSEKEEPING	825633	1.51	-825633	-3.03			10
11	DIETARY	1342444	2.46	-1342444	-4.93			11
12	CAFETERIA	76995	.14	-76995	-.28			12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	1336217	2.45	-1336217	-4.90			14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY	590506	1.08	-590506	-2.17			17
18	SOCIAL SERVICE							18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A							22
23	I&R SERVICES-OTHER PRGM COSTS A							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	14455530	26.50	17612898	64.63	32068428	58.78	25
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	45314	.08	18789	.07	64103	.12	41
44	LABORATORY	921901	1.69	413532	1.52	1335433	2.45	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
50	PHYSICAL THERAPY	57154	.10	38501	.14	95655	.18	50
54	ELECTROENCEPHALOGRAPHY							54
56	DRUGS CHARGED TO PATIENTS	1682822	3.08	769013	2.82	2451835	4.49	56
59	ADOLSCENT THERAPY							59
59.01	ECT	483768	.89	344266	1.26	828034	1.52	59.01
59.02	CHEMICAL DEPENDENCY							59.02
62	OBSERVATION BEDS (NON-DISTINCT							62
63	PARTIAL HOSPITALIZATION	2711066	4.97	2687073	9.86	5398139	9.89	63
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
97	RESEARCH	1563699	2.87	848639	3.11	2412338	4.42	97
98	PHYSICIANS' PRIVATE OFFICES	5311519	9.74	4473896	16.42	9785415	17.94	98
99	NONPAID WORKERS	72769	.13	45536	.17	118305	.22	99
100	GUEST MEALS							100
100.01	ADOLESCENT SCHOOL							100.01
100.02	MARKETING							100.02
100.03	OTHER NONREIMBURSEABLE							100.03
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	54557685	100.00	0	.00	54557685	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY-DIAGNOSTIC	1096	66121	.016576	49263	817	41
44	LABORATORY	23667	4280409	.005529	1509606	8347	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
50	PHYSICAL THERAPY	1791	308778	.005800	265555	1540	50
54	ELECTROENCEPHALOGRAPHY						54
56	DRUGS CHARGED TO PATIENTS	53655	6013509	.008922	3229692	28815	56
59	ADOLSCENT THERAPY						59
59.01	ECT	30039	2489340	.012067	683250	8245	59.01
59.02	CHEMICAL DEPENDENCY						59.02
	OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTINCT						62
	OTHER REIMBURSABLE COST CENTERS						
63	PARTIAL HOSPITALIZATION	236915	24526778	.009659			63
63.50	RHC						63.50
63.60	FQHC						63.60
101	TOTAL	347163	37684935		5737366	47764	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	TOTAL COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7
	INPATIENT ROUTINE SERVICE COST CENTERS							
25	ADULTS & PEDIATRICS	2047711		2047711	45933	44.58	18149	809082 25
101	TOTAL	2047711		2047711			18149	809082 101

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	809082
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	47764
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	856846
MEDICARE DISCHARGES (WORKSHEET S-3, LINE 8, COLUMN 13)	
MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 8, COLUMN 4)	
PER DISCHARGE CAPITAL COSTS	
PER DIEM CAPITAL COSTS	

I. COST TO CHARGE RATIO FOR FREESTANDING IPF

1.	TOTAL MEDICARE COSTS (WKST D-1 PART II LINE 49 - (WKST D PART III COLUMN 8 LINES 25-30 + WKST D PART IV COL 7 LINE 101))	14815991
2.	TOTAL MEDICARE CHARGES (WKST D-4 COLUMN 2 LINES 25-30 + LINE 103)	27985562
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.529

II. COST TO CHARGE RATIO FOR CAPITAL

1.	TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	856846
2.	RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.031

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	471301
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1878834
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.251