

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

- PROVIDER USE ONLY
1. ELECTRONICALLY FILED COST REPORT
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.
- DATE: _____ TIME: _____
- CONTRACTOR USE ONLY
5. COST REPORT STATUS
 6. DATE RECEIVED: _____
 7. CONTRACTOR NO: _____
 8. INITIAL REPORT FOR THIS PROVIDER CCN
 9. FINAL REPORT FOR THIS PROVIDER CCN
 10. NPR DATE: _____
 11. CONTRACTOR'S VENDOR CODE: _____
 12. IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED - 0-9.
- 1 - AS SUBMITTED
 - 2 - SETTLED WITHOUT AUDIT
 - 3 - SETTLED WITH AUDIT
 - 4 - REOPENED
 - 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY THOREK MEMORIAL HOSPITAL (14-0115) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2010 AND ENDING 06/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

TITLE

DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		99,808	-45,438		10,339,124	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		99,808	-45,438		10,339,124	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 850 WEST IRVING PARK ROAD
 2 CITY: CHICAGO

STATE: IL

P.O.BOX:
 ZIP CODE: 60613

COUNTY: COOK

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-0115	16974	1	07/01/1966	N	P	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF								7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTC								11
12	HOSPITAL-BASED HHA								12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC								15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2010			TO: 06/30/2011				20
21	TYPE OF CONTROL								21

INPATIENT PPS INFORMATION

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

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPFS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	11,417	480				24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1		26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1		27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:	36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.						37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:	38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

	V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N 45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N 46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N 47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N 48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
		Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N			61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER
 JULY 1, 2009 AND BEFORE JUNE 30, 2010.

64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON- PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)						
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
	1	2	3	4	5	

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS
 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010

66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66
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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME 1	PROGRAM CODE 2	UNWEIGHTED FTES NONPROVIDER SITE 3	UNWEIGHTED FTES IN HOSPITAL 4	RATIO (COL.1/ (COL.3+COL.4)) 5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.		N	85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.		N	90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?		N	105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.		N	108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	1 N	2 115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1	118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	30,000,000	30,000,000 119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N 120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y	121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2 140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

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

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B.

SEE 42 CFR §413.13)		PART A	PART B
155 HOSPITAL		1 N	2 N 155
156 SUBPROVIDER - IPF		N	N 156
157 SUBPROVIDER - IRF		N	N 157
158 SUBPROVIDER - (OTHER)		N	N 158
159 SNF		N	N 159
160 HHA		N	N 160
161 CMHC			N 161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.		
	NAME	COUNTY	STATE ZIP CODE CBSA FTE/CAMPUS
	0	1	2 3 4 5

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),		168

169 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.
IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1		1	2	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N		1
		Y/N	DATE	V/I
2		1	2	3
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N		2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
4		1	2	3
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N	
6		1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.			11
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	12/31/2011	Y	12/31/2011
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEF FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

- | | Y/N | DATE | |
|--|-----|------|--|
| | 1 | 2 | |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE	COMPONENT	WKST A NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			ALL PATIENTS
						TITLE V	TITLE XVIII	TITLE XIX	
						5	6	7	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	137	50,005		8,346	11,520	23,882	1
2	HMO						5		2
3	HMO IPF								3
4	HMO IRF								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		137	50,005		8,346	11,520	23,882	7
8	INTENSIVE CARE UNIT	31	10	3,650		1,118	617	2,312	8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)		147	53,655		9,464	12,137	26,194	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40							16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101							22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88							26
27	TOTAL (SUM OF LINES 14-26)		147						27
28	OBSERVATION BED DAYS						299	595	28
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
33	LTCH NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			DISCHARGES			TOTAL ALL PATIENTS 15
			TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					1,896	3,194	6,266
2	HMO								2
3	HMO IPF								3
4	HMO IRF								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)								7
8	INTENSIVE CARE UNIT	31							8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)						1,896	3,194	6,266
15	CAH VISITS			348.56					14
16	SUBPROVIDER - IPF	40							15
17	SUBPROVIDER - IRF	41							16
18	SUBPROVIDER I	42							17
19	SKILLED NURSING FACILITY	44							18
20	NURSING FACILITY	45							19
21	OTHER LONG TERM CARE	46							20
22	HOME HEALTH AGENCY	101							21
23	ASC (DISTINCT PART)	115							22
24	HOSPICE (DISTINCT PART)	116							23
25	CMHC	99							24
26	RHC	88							25
27	TOTAL (SUM OF LINES 14-26)			348.56					26
28	OBSERVATION BED DAYS								27
29	AMBULANCE TRIPS								28
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								29
31	EMPLOYEE DISCOUNT DAYS-IRF								30
32	LABOR & DELIVERY DAYS (SEE INSTR.)								31
33	LTCH NON-COVERED DAYS								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	19,963,739		19,963,739	725,011.00	27.54	1
2							2
3							3
4		257,811		257,811	3,232.00	79.77	4
4.01							4.01
5		1,288,952		1,288,952	20,775.00	62.04	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		796,779		796,779	16,027.00	49.71	10
11		144,489		144,489	2,096.00	68.94	11
12							12
13							13
14							14
15							15
16							16
17		2,926,065		2,926,065			17
18							18
19		132,316		132,316			19
20							20
21							21
22		42,813		42,813			22
23		214,047		214,047			23
24							24
25							25
26		94,969		94,969	2,949.00	32.20	26
27		3,626,097		3,626,097	109,326.00	33.17	27
28		59,725		59,725	313.00	190.81	28
29							29
30		455,275		455,275	19,448.00	23.41	30
31							31
32							32
33		640,181		640,181	45,730.50	14.00	33
34		442,595	-97,019	345,576	32,418.00	10.66	34
35							35
36			97,019	97,019	9,101.00	10.66	36
37							37
38		448,136		448,136	13,825.00	32.41	38
39		68,802		68,802	6,499.00	10.59	39
40		602,483		602,483	19,449.00	30.98	40
41		426,929		426,929	19,498.00	21.90	41
42		560,832		560,832	14,807.00	37.88	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1		19,374,693		19,374,693	750,279.50	25.82	1
2		796,779		796,779	16,027.00	49.71	2
3		18,577,914		18,577,914	734,252.50	25.30	3
4		144,489		144,489	2,096.00	68.94	4
5		2,968,878		2,968,878		15.98%	5
6		21,691,281		21,691,281	736,348.50	29.46	6
7		7,426,024		7,426,024	293,363.50	25.31	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	73,808	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,316,656	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	42,227	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	27,886	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	1,992	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	78,044	14
15 WORKERS' COMPENSATION INSURANCE	147,799	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	1,416,034	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	195,887	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	14,908	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	3,315,241	24

PART B - OTHER THAN CORE RELATED COST

25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.312247	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				18,551,960	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				40,987,971	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				12,798,371	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	3,406,647	901,387	4,308,034		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,063,715	281,455	1,345,170		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					22
23	COST OF CHARITY CARE	1,063,715	281,455	1,345,170		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			3,013,138		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			833,706		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			2,179,432		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			680,521		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,025,691		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,025,691		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		3,663,038	3,663,038	-904,616	1
2	00200				1,766,221	2
3	00300					3
4	00400	94,969	3,395,576	3,490,545		4
5	00500	3,626,097	10,729,903	14,356,000	-306,000	5
6	00600					6
7	00700	455,275	1,481,455	1,936,730		7
8	00800				262,929	8
9	00900		748,855	748,855		9
10	01000	442,595	813,109	1,255,704	-275,257	10
11	01100				275,257	11
12	01200					12
13	01300	448,136	152,853	600,989		13
14	01400	68,802	200,079	268,881	2,088,849	14
15	01500	602,483	4,010,510	4,612,993	-3,621,217	15
16	01600	426,929	425,853	852,782		16
17	01700	560,832	5,570	566,402		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	4,533,746	903,542	5,437,288	-227,858	30
31	03100	1,188,245	213,574	1,401,819	-88,666	31
ANCILLARY SERVICE COST CENTERS						
50	05000	849,614	1,585,539	2,435,153	-944,121	50
53	05300		467,303	467,303	-49,637	53
54	05400	779,374	718,471	1,497,845	-81,664	54
54.01	03630	157,955	13,280	171,235	-1,840	54.01
60	06000	1,033,729	1,727,031	2,760,760	-5,071	60
62.30	06250					62.30
65	06500	598,605	107,690	706,295	-38,122	65
66	06600	371	193,084	193,455	-904	66
69	06900	139,504	31,701	171,205	-10,565	69
69.01	03140	90,068	386,964	477,032	-266,040	69.01
70.01	03950					70.01
71	07100					71
72	07200					72
73	07300				3,573,187	73
74	07400		206,413	206,413		74
75	07500	415,057	33,154	448,211	-17,302	75
75.01	03480	207,759	55,969	263,728	-34,717	75.01
75.02	03340	39,846	142,513	182,359	-107,044	75.02
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	942,037	97,656	1,039,693	-17,676	90
90.01	09001	74,788	38,268	113,056	-31,856	90.01
91	09100	1,390,144	922,727	2,312,871	-117,736	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
113	11300		818,534	818,534	-818,534	113
118		19,166,960	34,290,214	53,457,174		118
NONREIMBURSABLE COST CENTERS						
190.01	19001					190.01
192	19200	547,130	268,426	815,556		192
192.01	19201	94,925	628,394	723,319		192.01
194	07950	154,724	10,432	165,156		194
200		19,963,739	35,197,466	55,161,205		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	2,758,422	-1,631,480	1,126,942	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,766,221	-1,178	1,765,043	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	3,490,545	-2,525	3,488,020	4
5	00500	ADMINISTRATIVE & GENERAL	14,050,000	-3,963,856	10,086,144	5
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,936,730		1,936,730	7
8	00800	LAUNDRY & LINEN SERVICE	262,929		262,929	8
9	00900	HOUSEKEEPING	748,855		748,855	9
10	01000	DIETARY	980,447		980,447	10
11	01100	CAFETERIA	275,257	-108,470	166,787	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	600,989	-9,278	591,711	13
14	01400	CENTRAL SERVICES & SUPPLY	2,357,730		2,357,730	14
15	01500	PHARMACY	991,776		991,776	15
16	01600	MEDICAL RECORDS & LIBRARY	852,782	-20,670	832,112	16
17	01700	SOCIAL SERVICE	566,402	-58,338	508,064	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	5,209,430	-70,348	5,139,082	30
31	03100	INTENSIVE CARE UNIT	1,313,153		1,313,153	31
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	1,491,032	-7,285	1,483,747	50
53	05300	ANESTHESIOLOGY	417,666	-335,350	82,316	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,416,181		1,416,181	54
54.01	03630	ULTRASOUND	169,395		169,395	54.01
60	06000	LABORATORY	2,755,689	-42,951	2,712,738	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	668,173	-6,942	661,231	65
66	06600	PHYSICAL THERAPY	192,551	-371	192,180	66
69	06900	ELECTROCARDIOLOGY	160,640	-18,628	142,012	69
69.01	03140	CARDIAC CATH LAB	210,992		210,992	69.01
70.01	03950	SLEEP LAB				70.01
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS				71
72	07200	IMPL. DEV. CHARGED TO PATIENT				72
73	07300	DRUGS CHARGED TO PATIENTS	3,573,187		3,573,187	73
74	07400	RENAL DIALYSIS	206,413		206,413	74
75	07500	ASC (NON-DISTINCT PART)	430,909		430,909	75
75.01	03480	ONCOLOGY	229,011		229,011	75.01
75.02	03340	GI LAB	75,315		75,315	75.02
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	CLINIC	1,022,017	-523,604	498,413	90
90.01	09001	WOUND CARE CENTER	81,200		81,200	90.01
91	09100	EMERGENCY	2,195,135	-1,236,775	958,360	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	53,457,174	-8,038,049	45,419,125	118
NONREIMBURSABLE COST CENTERS						
190.01	19001	SENIOR HEALTH				190.01
192	19200	PHYSICIANS' PRIVATE OFFICES	815,556	-512,628	302,928	192
192.01	19201	RETAIL PHARMACY	723,319		723,319	192.01
194	07950	SENIOR HEALTH	165,156		165,156	194
200		TOTAL (SUM OF LINES 118-199)	55,161,205	-8,550,677	46,610,528	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
	1	2	3	4	5
1 DEPRECIATION GL CC 8850-8581	A	CAP REL COSTS-MVBLE EQUIP	2		1,766,221 1
500 TOTAL RECLASSIFICATIONS					1,766,221 500
CODE LETTER - A					
1 INSURANCE	B	CAP REL COSTS-BLDG & FIXT	1		43,071 1
500 TOTAL RECLASSIFICATIONS					43,071 500
CODE LETTER - B					
1 DRUGS CHARGED	C	DRUGS CHARGED TO PATIENTS	73		3,573,187 1
500 TOTAL RECLASSIFICATIONS					3,573,187 500
CODE LETTER - C					
1 SUPPLIES CHARGED	D	CENTRAL SERVICES & SUPPLY	14		2,088,849 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
500 TOTAL RECLASSIFICATIONS					2,088,849 500
CODE LETTER - D					
1 CAFETERIA COSTS	E	CAFETERIA	11	97,019	178,238 1
500 TOTAL RECLASSIFICATIONS				97,019	178,238 500
CODE LETTER - E					
1 INTEREST	F	CAP REL COSTS-BLDG & FIXT	1		818,534 1
500 TOTAL RECLASSIFICATIONS					818,534 500
CODE LETTER - F					
1 LAUNDRY EXP	I	LAUNDRY & LINEN SERVICE	8		262,929 1
500 TOTAL RECLASSIFICATIONS					262,929 500
CODE LETTER - I					
GRAND TOTAL (INCREASES)				97,019	8,731,029

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF. 10
1 DEPRECIATION GL CC 8850-8581	A	CAP REL COSTS-BLDG & FIXT	1		1,766,221	9 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - A					1,766,221	500
1 INSURANCE	B	ADMINISTRATIVE & GENERAL	5		43,071	12 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - B					43,071	500
1 DRUGS CHARGED	C	PHARMACY	15		3,573,187	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - C					3,573,187	500
1 SUPPLIES CHARGED	D	PHARMACY	15		48,030	1
2		ADULTS & PEDIATRICS	30		227,858	2
3		INTENSIVE CARE UNIT	31		88,666	3
4		OPERATING ROOM	50		944,121	4
5		ANESTHESIOLOGY	53		49,637	5
6		RADIOLOGY-DIAGNOSTIC	54		81,664	6
7		ULTRASOUND	54.01		1,840	7
8		LABORATORY	60		5,071	8
9		RESPIRATORY THERAPY	65		38,122	9
10		PHYSICAL THERAPY	66		904	10
11		ELECTROCARDIOLOGY	69		10,565	11
12		CARDIAC CATH LAB	69.01		266,040	12
13		ASC (NON-DISTINCT PART)	75		17,302	13
14		ONCOLOGY	75.01		34,717	14
15		GI LAB	75.02		107,044	15
16		CLINIC	90		17,676	16
17		WOUND CARE CENTER	90.01		31,856	17
18		EMERGENCY	91		117,736	18
500 TOTAL RECLASSIFICATIONS CODE LETTER - D					2,088,849	500
1 CAFETERIA COSTS	E	DIETARY	10	97,019	178,238	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - E				97,019	178,238	500
1 INTEREST	F	INTEREST EXPENSE	113		818,534	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - F					818,534	500
1 LAUNDRY EXP	I	ADMINISTRATIVE & GENERAL	5		262,929	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - I					262,929	500
GRAND TOTAL (DECREASES)				97,019	8,731,029	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	9,426,777					9,426,777	1
2 LAND IMPROVEMENTS	1,511,394					1,511,394	2
3 BUILDINGS AND FIXTURES	29,375,543					29,375,543	3
4 BUILDING IMPROVEMENTS	20,102,665	783,956		783,956		20,886,621	4
5 FIXED EQUIPMENT	4,021,690	230,310		230,310		4,252,000	5
6 MOVABLE EQUIPMENT	20,789,828	378,709		378,709		21,168,537	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	85,227,897	1,392,975		1,392,975		86,620,872	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	85,227,897	1,392,975		1,392,975		86,620,872	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(1)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	3,663,038						3,663,038 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	3,663,038						3,663,038 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)	INSURANCE	TAXES	OTHER	TOTAL
							CAPITAL-RELATED COSTS	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE (SEE INSTR.)	TAXES (SEE INSTR.)	OTHER	TOTAL(2)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	12	13	14	15
1 CAP REL COSTS-BLDG & FIXT	1,298,322		-214,451	43,071			1,126,942 1
2 CAP REL COSTS-MVBLE EQUIP	1,765,043						1,765,043 2
3 TOTAL	3,063,365		-214,451	43,071			2,891,985 3

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-BUILDINGS & FIXTURES (CHAPTER 2)	B	-818,534	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-124	ADMINISTRATIVE & GENERAL	5	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)	B	-416,029	CAP REL COSTS-BLDG & FIXT	1	9 6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-50,185	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-13,547	ADMINISTRATIVE & GENERAL	5	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-2,384,874			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-106,924	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-5,539	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES	B	-1,546	CAFETERIA	11	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 MISC INCOME	B	-434,730	ADMINISTRATIVE & GENERAL	5	33
33.01 MISC. INCOME - TRANSPORTATION FARE	B	-1,220	ADMINISTRATIVE & GENERAL	5	33.01
33.02 PARKING LOT REVENUE	B	-174	ADMINISTRATIVE & GENERAL	5	33.02
34 1985 SERIES E BOND INTEREST	A	-214,451	CAP REL COSTS-BLDG & FIXT	1	11 34
35 HOSPITALITY EXP	A	-122,185	ADMINISTRATIVE & GENERAL	5	35
35.01 HOSPITALITY EXP	A	-3,809	NURSING ADMINISTRATION	13	35.01
35.02 HOSPITALITY EXP	A	-2,909	ADULTS & PEDIATRICS	30	35.02
35.03 HOSPITALITY EXP	A	-170	LABORATORY	60	35.03
35.04 HOSPITALITY EXP	A	-88	EMERGENCY	91	35.04
36 PATIENT PHONE	A	-1,178	CAP REL COSTS-MVBLE EQUIP	2	9 36
37 SPACE RENTAL IRVING PARK RD	B	-182,466	CAP REL COSTS-BLDG & FIXT	1	9 37
37.01 PHY PRACTICE REIMB INCOME	B	-1,352	ADMINISTRATIVE & GENERAL	5	37.01
38 PENALTY - CITY OF CHICAGO	A	-1,560	ADMINISTRATIVE & GENERAL	5	38
39 MEDICAL STAFF APPLICATION FEES	B	-16	ADMINISTRATIVE & GENERAL	5	39
39.01 BACKGROUND APPLICATION FEES	B	-8,595	ADMINISTRATIVE & GENERAL	5	39.01
40 POB PRO FEES	A	-512,628	PHYSICIANS' PRIVATE OFFICES	192	40
41 IHA DUES - LOBBYING PORTION	A	-19,580	ADMINISTRATIVE & GENERAL	5	41
42 MARKETING EXP	A	-103,255	ADMINISTRATIVE & GENERAL	5	42
43					43
43.01 TRAVEL EXP	A	-7,475	ADMINISTRATIVE & GENERAL	5	43.01
43.02 TRAVEL EXP	A	-5,469	NURSING ADMINISTRATION	13	43.02
43.03 TRAVEL EXP	A	-49,008	ADULTS & PEDIATRICS	30	43.03
44 BAD DEBTS	A	-3,013,138	ADMINISTRATIVE & GENERAL	5	44
44.02 MEDICARE PREMIUM PAID FOR EX EMPLO	A	-2,525	EMPLOYEE BENEFITS	4	44.02
44.03 EXTRAORDINARY LOSS	B	508	ADMINISTRATIVE & GENERAL	5	44.03
44.04 EMPLOYEES SUBLEASED TO POB	A	-59,056	CLINIC	90	44.04
45 ADVERTISING	A	-6,846	ADMINISTRATIVE & GENERAL	5	45
46					46
47					47

PROVIDER CCN: 14-0115 THOREK MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/29/2012 10:18

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-7	
				COST CENTER 3	LINE NO. 4	REF 5	
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-8,550,677				50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)					5
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					6
7					7
8					8
9					9
10					10

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2		3	4	5	6	7	8	9
2	5	ADMINISTRATIVE & GENERAL	180,382	180,382					2
4	16	MEDICAL RECORDS & LIBRAR	15,131	15,131					4
6	17	SOCIAL SERVICE	231,790		231,790	177,200	2,036	173,452	8,673
8	30	ADULTS & PEDIATRICS	18,431	18,431					8
10	50	OPERATING ROOM	7,285	7,285					10
12	53	ANESTHESIOLOGY	335,350	335,350					12
16	60	LABORATORY	42,781	42,781					16
18	65	RESPIRATORY THERAPY	11,968		11,968	177,200	59	5,026	251
20	66	PHYSICAL THERAPY	371	371					20
22	69	ELECTROCARDIOLOGY	18,628	18,628					22
24	90	CLINIC	464,548	464,548					24
26	91	EMERGENCY	1,236,687	1,236,687					26
200		TOTAL	2,563,352	2,319,594	243,758		2,095	178,478	8,924

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
2 5	ADMINISTRATIVE & GENERAL	AGGREGATE						180,382	2
4 16	MEDICAL RECORDS & LIBRAR	AGGREGATE						15,131	4
6 17	SOCIAL SERVICE	AGGREGATE				173,452	58,338	58,338	6
8 30	ADULTS & PEDIATRICS	AGGREGATE						18,431	8
10 50	OPERATING ROOM	AGGREGATE						7,285	10
12 53	ANESTHESIOLOGY	AGGREGATE						335,350	12
16 60	LABORATORY	AGGREGATE						42,781	16
18 65	RESPIRATORY THERAPY	AGGREGATE				5,026	6,942	6,942	18
20 66	PHYSICAL THERAPY	AGGREGATE						371	20
22 69	ELECTROCARDIOLOGY	AGGREGATE						18,628	22
24 90	CLINIC	AGGREGATE						464,548	24
26 91	EMERGENCY	AGGREGATE						1,236,687	26
200	TOTAL					178,478	65,280	2,384,874	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,126,942	1,126,942				1
2 CAP REL COSTS-MVBLE EQUIP	1,765,043		1,765,043			2
4 EMPLOYEE BENEFITS	3,488,020	3,338	5,228	3,496,586		4
5 ADMINISTRATIVE & GENERAL	10,086,144	179,399	280,979	638,135	11,184,657	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,936,730	393,805	616,788	80,121	3,027,444	7
8 LAUNDRY & LINEN SERVICE	262,929				262,929	8
9 HOUSEKEEPING	748,855	3,389	5,308		757,552	9
10 DIETARY	980,447	26,144	40,947	60,816	1,108,354	10
11 CAFETERIA	166,787	15,502	24,280	17,074	223,643	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	591,711	1,662	2,603	78,865	674,841	13
14 CENTRAL SERVICES & SUPPLY	2,357,730	25,427	39,824	12,108	2,435,089	14
15 PHARMACY	991,776	7,225	11,316	106,027	1,116,344	15
16 MEDICAL RECORDS & LIBRARY	832,112	7,095	11,112	75,133	925,452	16
17 SOCIAL SERVICE	508,064	4,385	6,868	98,697	618,014	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,139,082	197,597	309,480	797,870	6,444,029	30
31 INTENSIVE CARE UNIT	1,313,153	14,832	23,230	209,112	1,560,327	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,483,747	48,284	75,624	149,518	1,757,173	50
53 ANESTHESIOLOGY	82,316	1,504	2,355		86,175	53
54 RADIOLOGY-DIAGNOSTIC	1,416,181	40,678	63,710	137,157	1,657,726	54
54.01 ULTRASOUND	169,395	1,047	1,641	27,798	199,881	54.01
60 LABORATORY	2,712,738	26,432	41,399	181,920	2,962,489	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	661,231	13,980	21,895	105,345	802,451	65
66 PHYSICAL THERAPY	192,180	11,396	17,849	65	221,490	66
69 ELECTROCARDIOLOGY	142,012			24,550	166,562	69
69.01 CARDIAC CATH LAB	210,992	7,216	11,301	15,851	245,360	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	3,573,187				3,573,187	73
74 RENAL DIALYSIS	206,413	326	510		207,249	74
75 ASC (NON-DISTINCT PART)	430,909	37,102	58,111	73,043	599,165	75
75.01 ONCOLOGY	229,011	7,141	11,185	36,562	283,899	75.01
75.02 GI LAB	75,315			7,012	82,327	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	498,413	33,969	53,204	165,783	751,369	90
90.01 WOUND CARE CENTER	81,200	3,957	6,197	13,161	104,515	90.01
91 EMERGENCY	958,360	9,469	14,830	244,643	1,227,302	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	45,419,125	1,122,301	1,757,774	3,356,366	45,266,995	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	302,928	2,965	4,644	96,286	406,823	192
192.01 RETAIL PHARMACY	723,319	1,676	2,625	16,705	744,325	192.01
194 SENIOR HEALTH	165,156			27,229	192,385	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	46,610,528	1,126,942	1,765,043	3,496,586	46,610,528	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	11,184,657					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	955,825	3,983,269				7
8 LAUNDRY & LINEN SERVICE	83,012		345,941			8
9 HOUSEKEEPING	239,174	24,527		1,021,253		9
10 DIETARY	349,930	189,205		48,810	1,696,299	10
11 CAFETERIA	70,609	112,189		28,942		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	213,061	12,027		3,103		13
14 CENTRAL SERVICES & SUPPLY	768,806	184,016		47,471		14
15 PHARMACY	352,452	52,287		13,489		15
16 MEDICAL RECORDS & LIBRARY	292,184	51,344		13,245		16
17 SOCIAL SERVICE	195,119	31,736		8,187		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,034,510	1,430,016	235,887	368,908	1,546,580	30
31 INTENSIVE CARE UNIT	492,626	107,337	20,798	27,690	149,719	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	554,775	349,436	39,141	90,145		50
53 ANESTHESIOLOGY	27,207	10,882		2,807		53
54 RADIOLOGY-DIAGNOSTIC	523,377	294,386	26,641	75,944		54
54.01 ULTRASOUND	63,106	7,580		1,956		54.01
60 LABORATORY	935,317	191,293		49,349		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	253,350	101,172		26,100		65
66 PHYSICAL THERAPY	69,929	82,474		21,276		66
69 ELECTROCARDIOLOGY	52,587					69
69.01 CARDIAC CATH LAB	77,465	52,220		13,471		69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	1,128,127					73
74 RENAL DIALYSIS	65,433	2,358		608		74
75 ASC (NON-DISTINCT PART)	189,168	268,512	8,485	69,269		75
75.01 ONCOLOGY	89,633	51,681		13,332		75.01
75.02 GI LAB	25,992		8,485			75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	237,222	245,838		63,420		90
90.01 WOUND CARE CENTER	32,997	28,637	278	7,388		90.01
91 EMERGENCY	387,484	68,526	6,226	17,678		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	10,760,477	3,949,679	345,941	1,012,588	1,696,299	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	128,442	21,461		5,536		192
192.01 RETAIL PHARMACY	234,998	12,129		3,129		192.01
194 SENIOR HEALTH	60,740					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	11,184,657	3,983,269	345,941	1,021,253	1,696,299	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	435,383					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	10,915	913,947				13
14 CENTRAL SERVICES & SUPPLY			3,435,382			14
15 PHARMACY				1,534,572		15
16 MEDICAL RECORDS & LIBRARY	15,379				1,297,604	16
17 SOCIAL SERVICE	11,686					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	151,400	560,969		20,093	247,673	30
31 INTENSIVE CARE UNIT	28,297	104,847		5,254	43,355	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	22,224	82,345		19,187	33,090	50
53 ANESTHESIOLOGY				26,277	16,116	53
54 RADIOLOGY-DIAGNOSTIC	22,470			42,969	182,221	54
54.01 ULTRASOUND	3,512				22,601	54.01
60 LABORATORY	33,319				173,308	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	19,138				33,318	65
66 PHYSICAL THERAPY					3,706	66
69 ELECTROCARDIOLOGY	4,054			995	35,884	69
69.01 CARDIAC CATH LAB	2,429			1,088	19,818	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	5,121		2,848,125		55,176	71
72 IMPL. DEV. CHARGED TO PATIENT			587,257		15,024	72
73 DRUGS CHARGED TO PATIENTS	15,347			1,195,094	289,131	73
74 RENAL DIALYSIS					4,565	74
75 ASC (NON-DISTINCT PART)	10,488	38,862		874	13,090	75
75.01 ONCOLOGY	3,496	12,954		5,366	25,178	75.01
75.02 GI LAB	1,526			73	10,408	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	31,169			6,539	15,722	90
90.01 WOUND CARE CENTER	3,857	14,292		568	10,319	90.01
91 EMERGENCY	26,902	99,678		5,050	47,901	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	422,729	913,947	3,435,382	1,329,427	1,297,604	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	4,464			160		192
192.01 RETAIL PHARMACY	2,675			204,383		192.01
194 SENIOR HEALTH	5,515			602		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	435,383	913,947	3,435,382	1,534,572	1,297,604	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		3,338	5,228	8,566	8,566	4
5 ADMINISTRATIVE & GENERAL		179,399	280,979	460,378	1,563	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		393,805	616,788	1,010,593	196	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING		3,389	5,308	8,697		9
10 DIETARY		26,144	40,947	67,091	149	10
11 CAFETERIA		15,502	24,280	39,782	42	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		1,662	2,603	4,265	193	13
14 CENTRAL SERVICES & SUPPLY		25,427	39,824	65,251	30	14
15 PHARMACY		7,225	11,316	18,541	260	15
16 MEDICAL RECORDS & LIBRARY		7,095	11,112	18,207	184	16
17 SOCIAL SERVICE		4,385	6,868	11,253	242	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		197,597	309,480	507,077	1,955	30
31 INTENSIVE CARE UNIT		14,832	23,230	38,062	512	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		48,284	75,624	123,908	366	50
53 ANESTHESIOLOGY		1,504	2,355	3,859		53
54 RADIOLOGY-DIAGNOSTIC		40,678	63,710	104,388	336	54
54.01 ULTRASOUND		1,047	1,641	2,688	68	54.01
60 LABORATORY		26,432	41,399	67,831	446	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		13,980	21,895	35,875	258	65
66 PHYSICAL THERAPY		11,396	17,849	29,245		66
69 ELECTROCARDIOLOGY					60	69
69.01 CARDIAC CATH LAB		7,216	11,301	18,517	39	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS		326	510	836		74
75 ASC (NON-DISTINCT PART)		37,102	58,111	95,213	179	75
75.01 ONCOLOGY		7,141	11,185	18,326	90	75.01
75.02 GI LAB					17	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		33,969	53,204	87,173	406	90
90.01 WOUND CARE CENTER		3,957	6,197	10,154	32	90.01
91 EMERGENCY		9,469	14,830	24,299	599	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,122,301	1,757,774	2,880,075	8,222	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES		2,965	4,644	7,609	236	192
192.01 RETAIL PHARMACY		1,676	2,625	4,301	41	192.01
194 SENIOR HEALTH					67	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,126,942	1,765,043	2,891,985	8,566	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	461,941					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	39,478	1,050,267				7
8 LAUNDRY & LINEN SERVICE	3,429		3,429			8
9 HOUSEKEEPING	9,878	6,467		25,042		9
10 DIETARY	14,453	49,888		1,197	132,778	10
11 CAFETERIA	2,916	29,581		710		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	8,800	3,171		76		13
14 CENTRAL SERVICES & SUPPLY	31,754	48,520		1,164		14
15 PHARMACY	14,557	13,787		331		15
16 MEDICAL RECORDS & LIBRARY	12,068	13,538		325		16
17 SOCIAL SERVICE	8,059	8,368		201		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	84,016	377,048	2,338	9,045	121,059	30
31 INTENSIVE CARE UNIT	20,347	28,302	206	679	11,719	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	22,914	92,136	388	2,210		50
53 ANESTHESIOLOGY	1,124	2,869		69		53
54 RADIOLOGY-DIAGNOSTIC	21,617	77,621	264	1,862		54
54.01 ULTRASOUND	2,606	1,999		48		54.01
60 LABORATORY	38,631	50,438		1,210		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	10,464	26,676		640		65
66 PHYSICAL THERAPY	2,888	21,746		522		66
69 ELECTROCARDIOLOGY	2,172					69
69.01 CARDIAC CATH LAB	3,199	13,769		330		69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	46,594					73
74 RENAL DIALYSIS	2,703	622		15		74
75 ASC (NON-DISTINCT PART)	7,813	70,798	84	1,699		75
75.01 ONCOLOGY	3,702	13,627		327		75.01
75.02 GI LAB	1,074		84			75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	9,798	64,820		1,555		90
90.01 WOUND CARE CENTER	1,363	7,551	3	181		90.01
91 EMERGENCY	16,004	18,068	62	433		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	444,421	1,041,410	3,429	24,829	132,778	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	5,305	5,659		136		192
192.01 RETAIL PHARMACY	9,706	3,198		77		192.01
194 SENIOR HEALTH	2,509					194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	461,941	1,050,267	3,429	25,042	132,778	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	73,031					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,831	18,336				13
14 CENTRAL SERVICES & SUPPLY			146,719			14
15 PHARMACY				47,476		15
16 MEDICAL RECORDS & LIBRARY	2,580				46,902	16
17 SOCIAL SERVICE	1,960					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	25,398	11,254		622	8,951	30
31 INTENSIVE CARE UNIT	4,746	2,103		163	1,567	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,728	1,652		594	1,196	50
53 ANESTHESIOLOGY				813	582	53
54 RADIOLOGY-DIAGNOSTIC	3,769			1,329	6,586	54
54.01 ULTRASOUND	589				817	54.01
60 LABORATORY	5,589				6,264	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,210				1,204	65
66 PHYSICAL THERAPY					134	66
69 ELECTROCARDIOLOGY	680			31	1,297	69
69.01 CARDIAC CATH LAB	407			34	716	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	859		121,638		1,994	71
72 IMPL. DEV. CHARGED TO PATIENT			25,081		543	72
73 DRUGS CHARGED TO PATIENTS	2,574			36,972	10,455	73
74 RENAL DIALYSIS					165	74
75 ASC (NON-DISTINCT PART)	1,759	780		27	473	75
75.01 ONCOLOGY	586	260		166	910	75.01
75.02 GI LAB	256			2	376	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	5,228			202	568	90
90.01 WOUND CARE CENTER	647	287		18	373	90.01
91 EMERGENCY	4,512	2,000		156	1,731	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	70,908	18,336	146,719	41,129	46,902	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	749			5		192
192.01 RETAIL PHARMACY	449			6,323		192.01
194 SENIOR HEALTH	925			19		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	73,031	18,336	146,719	47,476	46,902	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	30,083				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	26,178	1,174,941		1,174,941	30
31 INTENSIVE CARE UNIT	3,141	111,547		111,547	31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		249,092		249,092	50
53 ANESTHESIOLOGY		9,316		9,316	53
54 RADIOLOGY-DIAGNOSTIC		217,772		217,772	54
54.01 ULTRASOUND		8,815		8,815	54.01
60 LABORATORY		170,409		170,409	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		78,327		78,327	65
66 PHYSICAL THERAPY		54,535		54,535	66
69 ELECTROCARDIOLOGY		4,240		4,240	69
69.01 CARDIAC CATH LAB		37,011		37,011	69.01
70.01 SLEEP LAB					70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		124,491		124,491	71
72 IMPL. DEV. CHARGED TO PATIENT		25,624		25,624	72
73 DRUGS CHARGED TO PATIENTS		96,595		96,595	73
74 RENAL DIALYSIS		4,341		4,341	74
75 ASC (NON-DISTINCT PART)		178,825		178,825	75
75.01 ONCOLOGY		37,994		37,994	75.01
75.02 GI LAB		1,809		1,809	75.02
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	113	169,863		169,863	90
90.01 WOUND CARE CENTER		20,609		20,609	90.01
91 EMERGENCY	651	68,515		68,515	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	30,083	2,844,671		2,844,671	118
NONREIMBURSABLE COST CENTERS					
190.01 SENIOR HEALTH					190.01
192 PHYSICIANS' PRIVATE OFFICES		19,699		19,699	192
192.01 RETAIL PHARMACY		24,095		24,095	192.01
194 SENIOR HEALTH		3,520		3,520	194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	30,083	2,891,985		2,891,985	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINISTRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	242,080					1
2 CAP REL COSTS-MVBLE EQUIP		242,080				2
4 EMPLOYEE BENEFITS	717	717	19,868,770			4
5 ADMINISTRATIVE & GENERAL	38,537	38,537	3,626,097	-11,184,657	35,425,871	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	84,594	84,594	455,275		3,027,444	7
8 LAUNDRY & LINEN SERVICE					262,929	8
9 HOUSEKEEPING	728	728			757,552	9
10 DIETARY	5,616	5,616	345,576		1,108,354	10
11 CAFETERIA	3,330	3,330	97,019		223,643	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	357	357	448,136		674,841	13
14 CENTRAL SERVICES & SUPPLY	5,462	5,462	68,802		2,435,089	14
15 PHARMACY	1,552	1,552	602,483		1,116,344	15
16 MEDICAL RECORDS & LIBRARY	1,524	1,524	426,929		925,452	16
17 SOCIAL SERVICE	942	942	560,832		618,014	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	42,446	42,446	4,533,746		6,444,029	30
31 INTENSIVE CARE UNIT	3,186	3,186	1,188,245		1,560,327	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,372	10,372	849,614		1,757,173	50
53 ANESTHESIOLOGY	323	323			86,175	53
54 RADIOLOGY-DIAGNOSTIC	8,738	8,738	779,374		1,657,726	54
54.01 ULTRASOUND	225	225	157,955		199,881	54.01
60 LABORATORY	5,678	5,678	1,033,729		2,962,489	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,003	3,003	598,605		802,451	65
66 PHYSICAL THERAPY	2,448	2,448	371		221,490	66
69 ELECTROCARDIOLOGY			139,504		166,562	69
69.01 CARDIAC CATH LAB	1,550	1,550	90,068		245,360	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					3,573,187	73
74 RENAL DIALYSIS	70	70			207,249	74
75 ASC (NON-DISTINCT PART)	7,970	7,970	415,057		599,165	75
75.01 ONCOLOGY	1,534	1,534	207,759		283,899	75.01
75.02 GI LAB			39,846		82,327	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	7,297	7,297	942,037		751,369	90
90.01 WOUND CARE CENTER	850	850	74,788		104,515	90.01
91 EMERGENCY	2,034	2,034	1,390,144		1,227,302	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	241,083	241,083	19,071,991	-11,184,657	34,082,338	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES	637	637	547,130		406,823	192
192.01 RETAIL PHARMACY	360	360	94,925		744,325	192.01
194 SENIOR HEALTH			154,724		192,385	194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,126,942	1,765,043	3,496,586		11,184,657	202
203 UNIT COST MULT-WS B PT I	4.655246	7.291156	0.175984		0.315720	203
204 COST TO BE ALLOC PER B PT II			8,566		461,941	204
205 UNIT COST MULT-WS B PT II			0.000431		0.013040	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
	OF PLANT	& LINEN	KEEPING		
	SQUARE	SERVICE	SQUARE	MEALS	FTE'S
	FEET	POUNDS OF	FEET	SERVED	
	7	LAUNDRY	8	10	11
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5					5
6					6
7	118,232				7
8		378,938			8
9	728		117,504		9
10	5,616		5,616	90,979	10
11	3,330		3,330		26,526
12					12
13	357		357		665
14	5,462		5,462		14
15	1,552		1,552		15
16	1,524		1,524		937
17	942		942		712
19					19
20					20
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30	42,446	258,388	42,446	82,949	9,224
31	3,186	22,782	3,186	8,030	1,724
ANCILLARY SERVICE COST CENTERS					
50	10,372	42,874	10,372		1,354
53	323		323		53
54	8,738	29,182	8,738		1,369
54.01	225		225		214
60	5,678		5,678		2,030
62.30					62.30
65	3,003		3,003		1,166
66	2,448		2,448		66
69					247
69.01	1,550		1,550		148
70.01					70.01
71					312
72					72
73					935
74	70		70		74
75	7,970	9,294	7,970		639
75.01	1,534		1,534		213
75.02		9,294			93
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
90	7,297		7,297		1,899
90.01	850	304	850		235
91	2,034	6,820	2,034		1,639
92					92
OTHER REIMBURSABLE COST CENTERS					
99.10					99.10
99.20					99.20
99.30					99.30
99.40					99.40
SPECIAL PURPOSE COST CENTERS					
118	117,235	378,938	116,507	90,979	25,755
NONREIMBURSABLE COST CENTERS					
190.01					190.01
192	637		637		272
192.01	360		360		163
194					336

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS OF LAUNDRY	SQUARE FEET	MEALS SERVED	FTE'S	
	7	8	9	10	11	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	3,983,269	345,941	1,021,253	1,696,299	435,383	202
203 UNIT COST MULT-WS B PT I	33.690278	0.912922	8.691219	18.644951	16.413443	203
204 COST TO BE ALLOC PER B PT II	1,050,267	3,429	25,042	132,778	73,031	204
205 UNIT COST MULT-WS B PT II	8.883103	0.009049	0.213116	1.459436	2.753186	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	15,028					13
14 CENTRAL SERVICES & SUPPLY		3,564,537				14
15 PHARMACY			4,588,177			15
16 MEDICAL RECORDS & LIBRARY				143,854,109		16
17 SOCIAL SERVICE					26,575	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	9,224		60,075	27,458,210	23,125	30
31 INTENSIVE CARE UNIT	1,724		15,708	4,806,580	2,775	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,354		57,366	3,668,470		50
53 ANESTHESIOLOGY			78,565	1,786,659		53
54 RADIOLOGY-DIAGNOSTIC			128,472	20,201,891		54
54.01 ULTRASOUND				2,505,680		54.01
60 LABORATORY				19,213,707		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY				3,693,820		65
66 PHYSICAL THERAPY				410,816		66
69 ELECTROCARDIOLOGY			2,976	3,978,284		69
69.01 CARDIAC CATH LAB			3,252	2,197,171		69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		2,955,202		6,117,021		71
72 IMPL. DEV. CHARGED TO PATIENT		609,335		1,665,608		72
73 DRUGS CHARGED TO PATIENTS			3,573,187	32,050,087		73
74 RENAL DIALYSIS				506,150		74
75 ASC (NON-DISTINCT PART)	639		2,612	1,451,208		75
75.01 ONCOLOGY	213		16,043	2,791,321		75.01
75.02 GI LAB			219	1,153,844		75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			19,550	1,743,020	100	90
90.01 WOUND CARE CENTER	235		1,698	1,144,005		90.01
91 EMERGENCY	1,639		15,099	5,310,557	575	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	15,028	3,564,537	3,974,822	143,854,109	26,575	118
NONREIMBURSABLE COST CENTERS						
190.01 SENIOR HEALTH						190.01
192 PHYSICIANS' PRIVATE OFFICES			477			192
192.01 RETAIL PHARMACY			611,079			192.01
194 SENIOR HEALTH			1,799			194

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSING HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME SPENT 17	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	913,947	3,435,382	1,534,572	1,297,604	864,742	202
203 UNIT COST MULT-WS B PT I	60.816276	0.963767	0.334462	0.009020	32.539680	203
204 COST TO BE ALLOC PER B PT II	18,336	146,719	47,476	46,902	30,083	204
205 UNIT COST MULT-WS B PT II	1.220122	0.041161	0.010347	0.000326	1.132004	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5	ADMINISTRATIVE & GENERAL	5
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
12	MAINTENANCE OF PERSONNEL	12
13	NURSING ADMINISTRATION	13
14	CENTRAL SERVICES & SUPPLY	14
15	PHARMACY	15
16	MEDICAL RECORDS & LIBRARY	16
17	SOCIAL SERVICE	17
19	NONPHYSICIAN ANESTHETISTS	19
20	NURSING SCHOOL	20
21	I&R SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM-(SPECIFY)	23
	INPATIENT ROUTINE SERV COST CENTERS	
30	ADULTS & PEDIATRICS	30
31	INTENSIVE CARE UNIT	31
	ANCILLARY SERVICE COST CENTERS	
50	OPERATING ROOM	50
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
54.01	ULTRASOUND	54.01
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
69	ELECTROCARDIOLOGY	69
69.01	CARDIAC CATH LAB	69.01
70.01	SLEEP LAB	70.01
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
74	RENAL DIALYSIS	74
75	ASC (NON-DISTINCT PART)	75
75.01	ONCOLOGY	75.01
75.02	GI LAB	75.02
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
	OUTPATIENT SERVICE COST CENTERS	
90	CLINIC	90
90.01	WOUND CARE CENTER	90.01
91	EMERGENCY	91
92	OBSERVATION BEDS	92
	OTHER REIMBURSABLE COST CENTERS	
99.10	CORF	99.10
99.20	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	OUTPATIENT SPEECH PATHOLOGY	99.40
	SPECIAL PURPOSE COST CENTERS	
118	SUBTOTALS (SUM OF LINES 1-117)	118
	NONREIMBURSABLE COST CENTERS	
190.01	SENIOR HEALTH	190.01
192	PHYSICIANS' PRIVATE OFFICES	192
192.01	RETAIL PHARMACY	192.01
194	SENIOR HEALTH	194

PROVIDER CCN: 14-0115 THOREK MEMORIAL HOSPITAL
PERIOD FROM 07/01/2010 TO 06/30/2011

KPMG LLP COMPU-MAX MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
01/29/2012 10:18

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,792,545		13,792,545		13,792,545	30
31 INTENSIVE CARE UNIT	2,630,548		2,630,548		2,630,548	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,947,516		2,947,516		2,947,516	50
53 ANESTHESIOLOGY	169,464		169,464		169,464	53
54 RADIOLOGY-DIAGNOSTIC	2,825,734		2,825,734		2,825,734	54
54.01 ULTRASOUND	298,636		298,636		298,636	54.01
60 LABORATORY	4,345,075		4,345,075		4,345,075	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,235,529		1,235,529	6,942	1,242,471	65
66 PHYSICAL THERAPY	398,875		398,875		398,875	66
69 ELECTROCARDIOLOGY	260,082		260,082		260,082	69
69.01 CARDIAC CATH LAB	411,851		411,851		411,851	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGED TO	2,908,422		2,908,422		2,908,422	71
72 IMPL. DEV. CHARGED TO PATIE	602,281		602,281		602,281	72
73 DRUGS CHARGED TO PATIENTS	6,200,886		6,200,886		6,200,886	73
74 RENAL DIALYSIS	280,213		280,213		280,213	74
75 ASC (NON-DISTINCT PART)	1,197,913		1,197,913		1,197,913	75
75.01 ONCOLOGY	485,539		485,539		485,539	75.01
75.02 GI LAB	128,811		128,811		128,811	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,354,533		1,354,533		1,354,533	90
90.01 WOUND CARE CENTER	202,851		202,851		202,851	90.01
91 EMERGENCY	1,905,457		1,905,457		1,905,457	91
92 OBSERVATION BEDS	335,277		335,277		335,277	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	44,918,038		44,918,038	6,942	44,924,980	200
201 LESS OBSERVATION BEDS	335,277		335,277		335,277	201
202 TOTAL (SEE INSTRUCTIONS)	44,582,761		44,582,761	6,942	44,589,703	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	26,573,998		26,573,998			30
31 INTENSIVE CARE UNIT	4,806,580		4,806,580			31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,940,451	1,728,019	3,668,470	0.803473	0.803473	0.803473 50
53 ANESTHESIOLOGY	748,073	1,038,586	1,786,659	0.094850	0.094850	0.094850 53
54 RADIOLOGY-DIAGNOSTIC	6,536,318	13,665,573	20,201,891	0.139875	0.139875	0.139875 54
54.01 ULTRASOUND	687,172	1,818,508	2,505,680	0.119184	0.119184	0.119184 54.01
60 LABORATORY	9,772,490	9,441,217	19,213,707	0.226145	0.226145	0.226145 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	3,492,635	201,185	3,693,820	0.334485	0.334485	0.336365 65
66 PHYSICAL THERAPY	198,772	212,044	410,816	0.970933	0.970933	0.970933 66
69 ELECTROCARDIOLOGY	2,166,498	1,811,786	3,978,284	0.065375	0.065375	0.065375 69
69.01 CARDIAC CATH LAB	1,652,410	544,761	2,197,171	0.187446	0.187446	0.187446 69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO	3,890,819	2,226,202	6,117,021	0.475464	0.475464	0.475464 71
72 IMPL. DEV. CHARGED TO PATIE	1,300,692	364,916	1,665,608	0.361598	0.361598	0.361598 72
73 DRUGS CHARGED TO PATIENTS	14,952,078	17,098,009	32,050,087	0.193475	0.193475	0.193475 73
74 RENAL DIALYSIS	501,375	4,775	506,150	0.553617	0.553617	0.553617 74
75 ASC (NON-DISTINCT PART)	358,624	1,092,584	1,451,208	0.825459	0.825459	0.825459 75
75.01 ONCOLOGY	53,533	2,737,788	2,791,321	0.173946	0.173946	0.173946 75.01
75.02 GI LAB	294,936	858,908	1,153,844	0.111636	0.111636	0.111636 75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	14,287	1,728,733	1,743,020	0.777118	0.777118	0.777118 90
90.01 WOUND CARE CENTER	65,857	1,078,148	1,144,005	0.177317	0.177317	0.177317 90.01
91 EMERGENCY	2,065,373	3,245,184	5,310,557	0.358805	0.358805	0.358805 91
92 OBSERVATION BEDS		884,212	884,212	0.379182	0.379182	0.379182 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	82,072,971	61,781,138	143,854,109			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	82,072,971	61,781,138	143,854,109			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST	SWING-BED	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,174,941		1,174,941	24,477	48.00	8,346	400,608	30
31 INTENSIVE CARE UNIT	111,547		111,547	2,312	48.25	1,118	53,944	31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,286,488		1,286,488	26,789		9,464	454,552	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [XX] TITLE XVIII-PT A [] TITLE XIX	[XX] HOSPITAL (14-0115) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA			
COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	249,092	3,668,470	0.067901	511,092	34,704	50
53	ANESTHESIOLOGY	9,316	1,786,659	0.005214	179,390	935	53
54	RADIOLOGY-DIAGNOSTIC	217,772	20,201,891	0.010780	3,112,575	33,554	54
54.01	ULTRASOUND	8,815	2,505,680	0.003518	331,318	1,166	54.01
60	LABORATORY	170,409	19,213,707	0.008869	4,382,259	38,866	60
62.30	BLOOD CLOTTING FOR HEMOPHILIA						62.30
65	RESPIRATORY THERAPY	78,327	3,693,820	0.021205	1,860,899	39,460	65
66	PHYSICAL THERAPY	54,535	410,816	0.132748	92,083	12,224	66
69	ELECTROCARDIOLOGY	4,240	3,978,284	0.001066	1,037,912	1,106	69
69.01	CARDIAC CATH LAB	37,011	2,197,171	0.016845	527,676	8,889	69.01
70.01	SLEEP LAB						70.01
71	MEDICAL SUPPLIES CHRGD TO PA	124,491	6,117,021	0.020352	1,868,185	38,021	71
72	IMPL. DEV. CHARGED TO PATIENT	25,624	1,665,608	0.015384	448,806	6,904	72
73	DRUGS CHARGED TO PATIENTS	96,595	32,050,087	0.003014	7,114,379	21,443	73
74	RENAL DIALYSIS	4,341	506,150	0.008577	225,454	1,934	74
75	ASC (NON-DISTINCT PART)	178,825	1,451,208	0.123225	115,145	14,189	75
75.01	ONCOLOGY	37,994	2,791,321	0.013611	34,343	467	75.01
75.02	GI LAB	1,809	1,153,844	0.001568	135,802	213	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	169,863	1,743,020	0.097453	3,265	318	90
90.01	WOUND CARE CENTER	20,609	1,144,005	0.018015	23,652	426	90.01
91	EMERGENCY	68,515	5,310,557	0.012902	664,234	8,570	91
92	OBSERVATION BEDS	28,561	884,212	0.032301			92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	1,586,744	112,473,531	112,473,531	22,668,469	263,389	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	24,477		8,346		30
31 INTENSIVE CARE UNIT	2,312		1,118		31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	26,789		9,464		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0115) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS. 1-4) 5	TOTAL O/P COST (SUM OF COLS. 2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 ULTRASOUND						54.01
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
69.01 CARDIAC CATH LAB						69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
75 ASC (NON-DISTINCT PART)						75
75.01 ONCOLOGY						75.01
75.02 GI LAB						75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
90.01 WOUND CARE CENTER						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (14-0115)	[] SUB (OTHER)	[] ICF/MR	[] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,668,470		511,092		345,241	50
53	ANESTHESIOLOGY	1,786,659		179,390		117,439	53
54	RADIOLOGY-DIAGNOSTIC	20,201,891		3,112,575		3,480,480	54
54.01	ULTRASOUND	2,505,680		331,318		273,110	54.01
60	LABORATORY	19,213,707		4,382,259		120,208	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	3,693,820		1,860,899		51,383	65
66	PHYSICAL THERAPY	410,816		92,083		130	66
69	ELECTROCARDIOLOGY	3,978,284		1,037,912		741,348	69
69.01	CARDIAC CATH LAB	2,197,171		527,676		325,996	69.01
70.01	SLEEP LAB						70.01
71	MEDICAL SUPPLIES CHRGED TO P	6,117,021		1,868,185		534,407	71
72	IMPL. DEV. CHARGED TO PATIEN	1,665,608		448,806		104,061	72
73	DRUGS CHARGED TO PATIENTS	32,050,087		7,114,379		5,716,303	73
74	RENAL DIALYSIS	506,150		225,454			74
75	ASC (NON-DISTINCT PART)	1,451,208		115,145		219,241	75
75.01	ONCOLOGY	2,791,321		34,343		747,168	75.01
75.02	GI LAB	1,153,844		135,802		166,048	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,743,020		3,265		424,710	90
90.01	WOUND CARE CENTER	1,144,005		23,652		577,278	90.01
91	EMERGENCY	5,310,557		664,234		325,590	91
92	OBSERVATION BEDS	884,212				18,662	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	112,473,531		22,668,469		14,288,803	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0115) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.803473	345,241			277,392			50
53 ANESTHESIOLOGY	0.094850	117,439			11,139			53
54 RADIOLOGY-DIAGNOSTIC	0.139875	3,480,480			486,832			54
54.01 ULTRASOUND	0.119184	273,110			32,550			54.01
60 LABORATORY	0.226145	120,208			27,184			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.334485	51,383			17,187			65
66 PHYSICAL THERAPY	0.970933	130			126			66
69 ELECTROCARDIOLOGY	0.065375	741,348			48,466			69
69.01 CARDIAC CATH LAB	0.187446	325,996			61,107			69.01
70.01 SLEEP LAB								70.01
71 MEDICAL SUPPLIES CHRGD TO PATI	0.475464	534,407			254,091			71
72 IMPL. DEV. CHARGED TO PATIENT	0.361598	104,061			37,628			72
73 DRUGS CHARGED TO PATIENTS	0.193475	5,716,303		7,672	1,105,962		1,484	73
74 RENAL DIALYSIS	0.553617							74
75 ASC (NON-DISTINCT PART)	0.825459	219,241			180,974			75
75.01 ONCOLOGY	0.173946	747,168			129,967			75.01
75.02 GI LAB	0.111636	166,048			18,537			75.02
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	0.777118	424,710			330,050			90
90.01 WOUND CARE CENTER	0.177317	577,278			102,361			90.01
91 EMERGENCY	0.358805	325,590			116,823			91
92 OBSERVATION BEDS	0.379182	18,662			7,076			92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		14,288,803		7,672	3,245,452		1,484	200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		14,288,803		7,672	3,245,452		1,484	202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0115) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	24,477	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	24,477	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	24,477	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	8,346	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	13,792,545	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	13,792,545	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	26,573,998	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	26,573,998	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.519024	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,085.67	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	13,792,545	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0115) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 563.49 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 4,702,888 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 4,702,888 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	2,630,548	2,312	1,137.78	1,118	1,272,038	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					5,688,713	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					11,663,639	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 454,552 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 263,389 51
 52 TOTAL PROGRAM EXCLUDABLE COST 717,941 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 10,945,698 53

TARGET AMOUNT AND LIMIT COMPUTATION
 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUC (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 595 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 563.49 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 335,277 89

	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	COST 1				
90 CAPITAL-RELATED COST	1,174,941	13,792,545	0.085187	335,277	28,561 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0115) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		9,701,880		30
31 INTENSIVE CARE UNIT		2,388,799		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.803473	511,092	410,649	50
53 ANESTHESIOLOGY	0.094850	179,390	17,015	53
54 RADIOLOGY-DIAGNOSTIC	0.139875	3,112,575	435,371	54
54.01 ULTRASOUND	0.119184	331,318	39,488	54.01
60 LABORATORY	0.226145	4,382,259	991,026	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.336365	1,860,899	625,941	65
66 PHYSICAL THERAPY	0.970933	92,083	89,406	66
69 ELECTROCARDIOLOGY	0.065375	1,037,912	67,853	69
69.01 CARDIAC CATH LAB	0.187446	527,676	98,911	69.01
70.01 SLEEP LAB				70.01
71 MEDICAL SUPPLIES CHRGD TO PATI	0.475464	1,868,185	888,255	71
72 IMPL. DEV. CHARGED TO PATIENT	0.361598	448,806	162,287	72
73 DRUGS CHARGED TO PATIENTS	0.193475	7,114,379	1,376,454	73
74 RENAL DIALYSIS	0.553617	225,454	124,815	74
75 ASC (NON-DISTINCT PART)	0.825459	115,145	95,047	75
75.01 ONCOLOGY	0.173946	34,343	5,974	75.01
75.02 GI LAB	0.111636	135,802	15,160	75.02
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.777118	3,265	2,537	90
90.01 WOUND CARE CENTER	0.177317	23,652	4,194	90.01
91 EMERGENCY	0.358805	664,234	238,330	91
92 OBSERVATION BEDS	0.379182			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		22,668,469	5,688,713	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		22,668,469		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0115)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	11,407,715	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	61,815	2
3	MANAGED CARE SIMULATED PAYMENTS	26,951	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	145.37	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.1829	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.4542	31
32	SUM OF LINES 30 AND 31	0.6371	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.4178	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	4,766,143	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	16,235,673	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	16,235,673	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,063,985	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK HOSPITAL (14-0115)
APPLICABLE BOX: SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)		52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	17,299,658	59
60	PRIMARY PAYER PAYMENTS	5,469	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	17,294,189	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	885,496	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	374,632	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	811,390	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	567,973	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	811,390	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	16,602,034	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	16,602,034	71
72	INTERIM PAYMENTS	16,502,226	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	99,808	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	426,649	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

CHECK APPLICABLE BOX: HOSPITAL (14-0115) IPF IRF
 SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	1,484	1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (SEE INSTRUCTIONS)	3,245,452	2
3	PPS PAYMENTS	3,641,533	3
4	OUTLIER PAYMENT (SEE INSTRUCTIONS)	1,675	4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (SEE INSTRUCTIONS)	0.820	5
6	LINE 2 TIMES LINE 5	2,661,271	6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6		7
8	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)		8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200		9
10	ORGAN ACQUISITION		10
11	TOTAL COST (SUM OF LINES 1 AND 10) (SEE INSTRUCTIONS)	1,484	11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
12	ANCILLARY SERVICE CHARGES	7,672	12
13	ORGAN ACQUISITION CHARGES (FROM WKST D-4, PART III, LINE 69, COL. 4)		13
14	TOTAL REASONABLE CHARGES (SUM OF LINES 12 AND 13)	7,672	14
	CUSTOMARY CHARGES		
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		16
17	RATIO OF LINE 15 TO LINE 16 (NOT TO EXCEED 1.000000)	1.000000	17
18	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	7,672	18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 18 EXCEEDS LINE 11 (SEE INSTRUCTIONS))	6,188	19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 11 EXCEEDS LINE 18 (SEE INSTRUCTIONS))		20
21	LESSER OF COST OR CHARGES (LINE 11 MINUS LINE 20) (FOR CAH, SEE INSTRUCTIONS)	1,484	21
22	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		22
23	COST OF TEACHING PHYSICIANS (SEE INSTR., 42 CFR 415.160 AND CMS PUB. 15-1 §2148)		23
24	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 3, 4, 8 AND 9)	3,643,208	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (SEE INSTRUCTIONS)	835,097	26
27	SUBTOTAL {(LINES 21 AND 24 - THE SUM OF LINES 25 AND 26) PLUS THE SUM OF LINES 22 AND 23} (SEE INSTRUCTIONS)	2,809,595	27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 50)		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (FROM WKST E-4, LINE 36)		29
30	SUBTOTAL (SUM OF LINES 27 THROUGH 29)	2,809,595	30
31	PRIMARY PAYER PAYMENTS	856	31
32	SUBTOTAL (LINE 30 MINUS LINE 31)	2,808,739	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	COMPOSITE RATE ESRD (FROM WKST I-5, LINE 11)		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	379,619	34
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	265,733	35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	379,619	36
37	SUBTOTAL (SUM OF LINES 32, 33 AND 34 OR 35) (LINE 35 HOSPITAL AND SUBPROVIDERS ONLY)	3,074,472	37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R	-31	38
39	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		39
40	SUBTOTAL (LINE 37 PLUS OR MINUS LINES 39 MINUS 38)	3,074,503	40
41	INTERIM PAYMENTS	3,119,941	41
42	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		42
43	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS THE SUM OF LINES 41 AND 42)	-45,438	43
44	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		44
	TO BE COMPLETED BY CONTRACTOR		
90	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)		90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		92
93	TIME VALUE OF MONEY (SEE INSTRUCTIONS)		93
94	TOTAL (SUM OF LINES 91 AND 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0115) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		17,339,844		2,807,945	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.		61,815		242,871	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 06/10/2011	NONE		69,125	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50			NONE	3.50
	.51 06/10/2011	899,433			3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	-899,433		69,125	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		16,502,226		3,119,941	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT					
	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .02				6.02
	TO .02				6.02
	PROGRAM				7
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0115) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14 6,266 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12 9,464 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12 26,194 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200 143,854,109 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20 4,308,034 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS) 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH	
30	INITIAL/INTERIM HIT PAYMENT(S) 30
31	OTHER ADJUSTMENTS (SPECIFY) 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31) 32

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	9,221,736			1
2 TEMPORARY INVESTMENTS	8,007,320			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	21,277,039			4
5 OTHER RECEIVABLES	1,771,655			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-18,802,690			6
7 INVENTORY	878,903			7
8 PREPAID EXPENSES	1,238,182			8
9 OTHER CURRENT ASSETS	10,660,587			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	34,252,732			11
FIXED ASSETS				
12 LAND	9,426,777			12
13 LAND IMPROVEMENTS	1,511,394			13
14 ACCUMULATED DEPRECIATION	-1,219,011			14
15 BUILDINGS	50,262,165			15
16 ACCUMULATED DEPRECIATION	-28,807,911			16
17 LEASEHOLD IMPROVEMENTS	18,103			17
18 ACCUMULATED AMORTIZATION	-18,103			18
19 FIXED EQUIPMENT	4,252,000			19
20 ACCUMULATED DEPRECIATION	-3,382,193			20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	21,168,537			23
24 ACCUMULATED DEPRECIATION	-14,208,168			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	39,003,590			30
OTHER ASSETS				
31 INVESTMENTS	159,942,628			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	77,508			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	160,020,136			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	233,276,458			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	1,167,291			37
38 SALARIES, WAGES & FEES PAYABLE	909,748			38
39 PAYROLL TAXES PAYABLE	66,865			39
40 NOTES & LOANS PAYABLE (SHORT TERM)	3,940,156			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	18,222,190			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	24,306,250			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	14,628,334			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	4,410,035			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	19,038,369			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	43,344,619			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	189,931,839			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	189,931,839			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF	233,276,458			60

LINES 51 AND 59)

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		153,540,979							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		36,390,858							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		189,931,837							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 RECONCILING DIFFERENCE	2								5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)								2	10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		189,931,839							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 RECONCILING DIFFERENCE									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		189,931,839							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	26,573,998		26,573,998	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF				5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	26,573,998		26,573,998	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT	4,806,580		4,806,580	11
12 CORONARY CARE UNIT				12
13 BURN INTENSIVE CARE UNIT				13
14 SURGICAL INTENSIVE CARE UNIT				14
15 OTHER SPECIAL CARE (SPECIFY)				15
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	4,806,580		4,806,580	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	31,380,578		31,380,578	17
18 ANCILLARY SERVICES	50,682,394	65,359,047	116,041,441	18
19 OUTPATIENT SERVICES				19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	82,062,972	65,359,047	147,422,019	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		55,161,205	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		55,161,205	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	147,422,019	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	93,634,542	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	53,787,477	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	55,161,205	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-1,373,728	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	28,210,607	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	124	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS	174	12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	106,924	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	5,539	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,546	21
22	RENTAL OF HOSPITAL SPACE	598,495	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (TRANSPORTATION FARE)	1,220	24
24.01	OTHER (OTHER INCOME)	434,730	24.01
24.02	OTHER (PROVIDER TAX REVENUE)	8,395,773	24.02
24.03	OTHER (MEMBERSHIP APPLICATION FEES)	16	24.03
24.04	OTHER (BACKGROUND APPLICATION FEES)	8,595	24.04
24.05	OTHER (PHYS PRACTICE REIMBURSEMENT)	1,352	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	37,765,095	25
26	TOTAL (LINE 5 PLUS LINE 25)	36,391,367	26
27	OTHER EXPENSES (EXTRA ORDINARY LOSS)	509	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	509	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	36,390,858	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-011)) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	930,461	1
2	CAPITAL DRG OUTLIER PAYMENTS	5,400	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	71.76	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.1829	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.4542	8
9	SUM OF LINES 7 AND 8	0.6371	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1377	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	128,124	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	1,063,985	12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)		3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI-	SUBTOTAL	I&R COST &		TOTAL
	NARY CAP- REL COSTS	(COLS.0-4)	SUBTOTAL	POST STEP- DOWN ADJS	
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.01 ULTRASOUND					54.01
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
69.01 CARDIAC CATH LAB					69.01
70.01 SLEEP LAB					70.01
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
75 ASC (NON-DISTINCT PART)					75
75.01 ONCOLOGY					75.01
75.02 GI LAB					75.02
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 WOUND CARE CENTER					90.01
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190.01 SENIOR HEALTH					190.01
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 RETAIL PHARMACY					192.01
194 SENIOR HEALTH					194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6		
UTILIZATION PERCENTAGES BASED ON DAYS								
30 ADULTS & PEDIATRICS	34.10		47.06				81.16	30
31 INTENSIVE CARE UNIT	48.36		26.69				75.05	31
UTILIZATION PERCENTAGES BASED ON CHARGES								
50 OPERATING ROOM	13.93	9.41	12.67				36.01	50
53 ANESTHESIOLOGY	10.04	6.57	5.72				22.33	53
54 RADIOLOGY-DIAGNOSTIC	15.41	17.23	7.68				40.32	54
54.01 ULTRASOUND	13.22	10.90					24.12	54.01
60 LABORATORY	22.81	0.63	20.81				44.25	60
65 RESPIRATORY THERAPY	50.38	1.39	27.45				79.22	65
66 PHYSICAL THERAPY	22.41	0.03	6.13				28.57	66
69 ELECTROCARDIOLOGY	26.09	18.63	12.88				57.60	69
69.01 CARDIAC CATH LAB	24.02	14.84	13.52				52.38	69.01
71 MEDICAL SUPPLIES CHRGED TO PATI	30.54	8.74	18.48				57.76	71
72 IMPL. DEV. CHARGED TO PATIENT	26.95	6.25					33.20	72
73 DRUGS CHARGED TO PATIENTS	22.20	17.84	9.04				49.08	73
74 RENAL DIALYSIS	44.54		17.17				61.71	74
75 ASC (NON-DISTINCT PART)	7.93	15.11					23.04	75
75.01 ONCOLOGY	1.23	26.77	0.03				28.03	75.01
75.02 GI LAB	11.77	14.39	5.28				31.44	75.02
90 CLINIC	0.19	24.37	0.56				25.12	90
90.01 WOUND CARE CENTER	2.07	50.46					52.53	90.01
91 EMERGENCY	12.51	6.13	1.45				20.09	91
92 OBSERVATION BEDS		2.11					2.11	92
200 TOTAL CHARGES	20.15	12.70	10.87				43.72	200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,126,942	2.42	-1,126,942	-4.36		1
2	CAP REL COSTS-MVBLE EQUIP	1,765,043	3.79	-1,765,043	-6.83		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	3,488,020	7.48	-3,488,020	-13.50		4
5	ADMINISTRATIVE & GENERAL	10,086,144	21.64	-10,086,144	-39.03		5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,936,730	4.16	-1,936,730	-7.49		7
8	LAUNDRY & LINEN SERVICE	262,929	0.56	-262,929	-1.02		8
9	HOUSEKEEPING	748,855	1.61	-748,855	-2.90		9
10	DIETARY	980,447	2.10	-980,447	-3.79		10
11	CAFETERIA	166,787	0.36	-166,787	-0.65		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	591,711	1.27	-591,711	-2.29		13
14	CENTRAL SERVICES & SUPPLY	2,357,730	5.06	-2,357,730	-9.12		14
15	PHARMACY	991,776	2.13	-991,776	-3.84		15
16	MEDICAL RECORDS & LIBRARY	832,112	1.79	-832,112	-3.22		16
17	SOCIAL SERVICE	508,064	1.09	-508,064	-1.97		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,139,082	11.03	8,653,463	33.48	13,792,545	29.59
31	INTENSIVE CARE UNIT	1,313,153	2.82	1,317,395	5.10	2,630,548	5.64
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,483,747	3.18	1,463,769	5.66	2,947,516	6.32
53	ANESTHESIOLOGY	82,316	0.18	87,148	0.34	169,464	0.36
54	RADIOLOGY-DIAGNOSTIC	1,416,181	3.04	1,409,553	5.45	2,825,734	6.06
54.01	ULTRASOUND	169,395	0.36	129,241	0.50	298,636	0.64
60	LABORATORY	2,712,738	5.82	1,632,337	6.32	4,345,075	9.32
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	661,231	1.42	574,298	2.22	1,235,529	2.65
66	PHYSICAL THERAPY	192,180	0.41	206,695	0.80	398,875	0.86
69	ELECTROCARDIOLOGY	142,012	0.30	118,070	0.46	260,082	0.56
69.01	CARDIAC CATH LAB	210,992	0.45	200,859	0.78	411,851	0.88
70.01	SLEEP LAB						70.01
71	MEDICAL SUPPLIES CHRGD TO PATI			2,908,422	11.25	2,908,422	6.24
72	IMPL. DEV. CHARGED TO PATIENT			602,281	2.33	602,281	1.29
73	DRUGS CHARGED TO PATIENTS	3,573,187	7.67	2,627,699	10.17	6,200,886	13.30
74	RENAL DIALYSIS	206,413	0.44	73,800	0.29	280,213	0.60
75	ASC (NON-DISTINCT PART)	430,909	0.92	767,004	2.97	1,197,913	2.57
75.01	ONCOLOGY	229,011	0.49	256,528	0.99	485,539	1.04
75.02	GI LAB	75,315	0.16	53,496	0.21	128,811	0.28
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
90	CLINIC	498,413	1.07	856,120	3.31	1,354,533	2.91
90.01	WOUND CARE CENTER	81,200	0.17	121,651	0.47	202,851	0.44
91	EMERGENCY	958,360	2.06	947,097	3.66	1,905,457	4.09
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190.01	SENIOR HEALTH						190.01
192	PHYSICIANS' PRIVATE OFFICES	302,928	0.65	263,958	1.02	566,886	1.22
192.01	RETAIL PHARMACY	723,319	1.55	478,320	1.85	1,201,639	2.58
194	SENIOR HEALTH	165,156	0.35	94,086	0.36	259,242	0.56
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	46,610,528	100.00			46,610,528	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		CAPITAL		PROGRAM	
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL	
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	249,092	3,668,470	0.067901	511,092	34,704	50
53 ANESTHESIOLOGY	9,316	1,786,659	0.005214	179,390	935	53
54 RADIOLOGY-DIAGNOSTIC	217,772	20,201,891	0.010780	3,112,575	33,554	54
54.01 ULTRASOUND	8,815	2,505,680	0.003518	331,318	1,166	54.01
60 LABORATORY	170,409	19,213,707	0.008869	4,382,259	38,866	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	78,327	3,693,820	0.021205	1,860,899	39,460	65
66 PHYSICAL THERAPY	54,535	410,816	0.132748	92,083	12,224	66
69 ELECTROCARDIOLOGY	4,240	3,978,284	0.001066	1,037,912	1,106	69
69.01 CARDIAC CATH LAB	37,011	2,197,171	0.016845	527,676	8,889	69.01
70.01 SLEEP LAB						70.01
71 MEDICAL SUPPLIES CHRGD TO PATI	124,491	6,117,021	0.020352	1,868,185	38,021	71
72 IMPL. DEV. CHARGED TO PATIENT	25,624	1,665,608	0.015384	448,806	6,904	72
73 DRUGS CHARGED TO PATIENTS	96,595	32,050,087	0.003014	7,114,379	21,443	73
74 RENAL DIALYSIS	4,341	506,150	0.008577	225,454	1,934	74
75 ASC (NON-DISTINCT PART)	178,825	1,451,208	0.123225	115,145	14,189	75
75.01 ONCOLOGY	37,994	2,791,321	0.013611	34,343	467	75.01
75.02 GI LAB	1,809	1,153,844	0.001568	135,802	213	75.02
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	169,863	1,743,020	0.097453	3,265	318	90
90.01 WOUND CARE CENTER	20,609	1,144,005	0.018015	23,652	426	90.01
91 EMERGENCY	68,515	5,310,557	0.012902	664,234	8,570	91
92 OBSERVATION BEDS	28,561	884,212	0.032301			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	1,586,744	112,473,531		22,668,469	263,389	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION		CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	REDUCED CAPITAL RELATED COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7	
INPATIENT ROUTINE SERVICE COST CENTERS									
30	ADULTS & PEDIATRICS	1,174,941		1,174,941	24,477	48.00	8,346	400,608	30
31	INTENSIVE CARE UNIT	111,547		111,547	2,312	48.25	1,118	53,944	31
200	TOTAL	1,286,488		1,286,488	26,789		9,464	454,552	200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								454,552	
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								263,389	
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								717,941	
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,896	
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								9,464	
PER DISCHARGE CAPITAL COSTS								378.66	
PER DIEM CAPITAL COSTS								75.86	

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	10,945,698
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	34,759,148
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.315

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	717,941
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.021

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	3,245,326
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	14,288,673
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.227