

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 DATE: _____ TIME: _____
 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.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 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 SACRED HEART HOSPITAL (14-0151) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2011 AND ENDING 06/30/2012, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		473,995	303,645	-94,945		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		473,995	303,645	-94,945		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: 3240 W. FRANKLIN BLVD
 2 CITY: CHICAGO

STATE: IL

P.O.BOX:

ZIP CODE: 60624

COUNTY: COOK

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O, OR N)			
							2	3	4	5
3	HOSPITAL	SACRED HEART HOSPITAL	14-0151	16974	1	07/01/1988	N	P	P	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: 07/01/2011				TO: 06/30/2012				20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

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.								1	2
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		OUT-OF-STATE MEDICAID		OUT-OF-STATE MEDICAID		OTHER	
		PAID	UNPAID	PAID	UNPAID	HMO	MEDICAID		
		DAYS	DAYS	DAYS	DAYS	DAYS	DAYS		
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	8,350					181		24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID 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 IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1				27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE 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.	Y			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE 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 2148? IF YES, COMPLETE WORKSHEET D-5.	N			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
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)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	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
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, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL 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 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.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

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	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	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.			V 1 XIX 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 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.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N N N Y 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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 3,000,000 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR 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	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, LINE 74 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)

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	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	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.	Y		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH	1.00		169

(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

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
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)	1 N	2	1
		Y/N	DATE	V/I
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.	1 N	2	3 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	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.	1 Y	2 A	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	1	Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
				Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15

		PART A		PART B	
		Y/N	DATE	Y/N	DATE
PS&R REPORT DATA					
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)	1 N	2	3 N	4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	11/16/2012	Y	11/16/2012 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND 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 RELIEFED 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	
36	1	2	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? 36
37			IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 37
38	N		IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. 38
39			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. 39
40			IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. 40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: JANE	LAST NAME: BACHMANN	TITLE: CONSULTANT	41
42	EMPLOYER: BACHMANN ASSOCIATES			42
43	PHONE NUMBER: 7083831860	E-MAIL ADDRESS: JBOPIL@ATT.NET		43

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	TOTAL SALARIES (SEE INSTRUCTIONS)	200	11,692,578	11,692,578	464,838.00	25.15	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B		247,375	247,375	3,424.00	72.25	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21	188,102	188,102	12,480.00	15.07	7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF	44					9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		398,477	159,717	558,194	15,601.00	35.78
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)		42,609	42,609	719.00	59.26	11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE						15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		2,039,594	2,039,594			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		106,412	106,412			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A - ADMINISTRATIVE						22
22.01	PHYSICIAN PART A - TEACHING						22.01
23	PHYSICIAN PART B		47,159	47,159			23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)		35,859	35,859			25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS						26
27	ADMINISTRATIVE & GENERAL		2,247,841	-100,271	2,147,570	66,248.00	32.42
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		167,361		167,361	478.10	350.05
29	MAINTENANCE & REPAIRS		183,028		183,028	9,630.40	19.01
30	OPERATION OF PLANT						30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING		234,420		234,420	23,171.20	10.12
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY		314,821	-108,831	205,990	14,276.51	14.43
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)		93,989		93,989	7,884.50	11.92
36	CAFETERIA			108,831	108,831	7,542.69	14.43
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION		248,413		248,413	5,553.60	44.73
39	CENTRAL SERVICES AND SUPPLY		77,241		77,241	4,139.20	18.66
40	PHARMACY						40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		184,238		184,238	8,840.00	20.84
42	SOCIAL SERVICE		46,818		46,818	2,080.00	22.51
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	11,518,451		11,518,451	457,296.60	25.19	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	398,477	159,717	558,194	15,601.00	35.78	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	11,119,974	-159,717	10,960,257	441,695.60	24.81	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	42,609		42,609	719.00	59.26	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,039,594		2,039,594		18.61%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	13,202,177	-159,717	13,042,460	442,414.60	29.48	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	3,798,170	-100,271	3,697,899	149,844.20	24.68	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS	43,251	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	16,850	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	711,534	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN	16,146	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	10,453	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	53,598	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	225,243	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	836,480	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	24,842	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	290,626	20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT		23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,229,023	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
11/20/2012 10:36

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	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL	42,609	2
3	SUBPROVIDER - IPF	42,609	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 OLTIC		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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.267589	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				9,558,858	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				6,843,618	5
6	MEDICAID CHARGES				31,388,175	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				8,399,130	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				851,695	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 FACILITY		19,404			19,404 20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)		5,192			5,192 21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE					0 22
23	COST OF CHARITY CARE		5,192			5,192 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 IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					N 24
25	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)					25
26	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				4,933,290	26
27	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				829,792	27
28	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				1,098,051	29
29	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				1,103,243	30
30	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,103,243	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,896,206	1,896,206	-972,833	1
2	00200				976,293	2
3	00300					3
4	00400		1,490,024	1,490,024		4
5.10	00540	41,507	146,565	188,072		5.10
5.20	00550	136,143	186,284	322,427		5.20
5.30	00560	93,755	78,721	172,476		5.30
5.40	00580	567,445	151,565	719,010		5.40
5.50	00590	1,408,991	1,581,798	2,990,789	-100,271	5.50
6	00600	183,028	192,295	375,323		6
7	00700		859,069	859,069		7
8	00800				133,001	8
9	00900	234,420	244,225	478,645	-133,001	9
10	01000	314,821	435,961	750,782	-259,539	10
11	01100				259,539	11
13	01300	248,413	52,213	300,626		13
14	01400	77,241	212,868	290,109		14
15	01500					15
16	01600	184,238	125,577	309,815		16
17	01700	46,818	3,849	50,667		17
19	01900					19
21	02100	188,102	119,986	308,088		21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	2,207,512	489,356	2,696,868	-30,021	30
31	03100	873,280	99,352	972,632	-7,808	31
ANCILLARY SERVICE COST CENTERS						
50	05000	761,866	1,051,564	1,813,430	-848,474	50
51	05100	118,136	10,914	129,050	-2,124	51
53	05300	53,075	722,412	775,487	-18,458	53
54	05400	646,612	448,947	1,095,559	81,036	54
56	05600	91,744	52,313	144,057	-144,057	56
60	06000	625,137	915,913	1,541,050	-50,052	60
62.30	06250					62.30
65	06500	355,514	202,998	558,512	-33,896	65
66	06600	142,288	24,155	166,443	-2,742	66
69	06900	73,051	13,241	86,292	-1,936	69
70	07000		62,440	62,440		70
70.50	03951				14,647	70.50
71	07100				920,657	71
72	07200				169,876	72
73	07300	325,205	1,061,576	1,386,781	-28,276	73
76	03950					76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	796,273	456,683	1,252,956	-70,113	90
91	09100	499,486	816,653	1,316,139	-7,705	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		3,460	3,460	-3,460	113
118		11,294,101	14,209,183	25,503,284	-159,717	118
NONREIMBURSABLE COST CENTERS						
192	19200	398,477	542,998	941,475	59,446	192
194	07950				100,271	194
200		11,692,578	14,752,181	26,444,759		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	923,373	-596,446	326,927	1
2	00200	976,293	-177,719	798,574	2
3	00300				3
4	00400	1,490,024		1,490,024	4
5.10	00540	188,072		188,072	5.10
5.20	00550	322,427		322,427	5.20
5.30	00560	172,476		172,476	5.30
5.40	00580	719,010		719,010	5.40
5.50	00590	2,890,518	-499,904	2,390,614	5.50
6	00600	375,323		375,323	6
7	00700	859,069		859,069	7
8	00800	133,001		133,001	8
9	00900	345,644		345,644	9
10	01000	491,243		491,243	10
11	01100	259,539	-29,485	230,054	11
13	01300	300,626		300,626	13
14	01400	290,109		290,109	14
15	01500				15
16	01600	309,815	-14,083	295,732	16
17	01700	50,667		50,667	17
19	01900				19
21	02100	308,088	-38,000	270,088	21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	2,666,847	-148,208	2,518,639	30
31	03100	964,824		964,824	31
ANCILLARY SERVICE COST CENTERS					
50	05000	964,956		964,956	50
51	05100	126,926		126,926	51
53	05300	757,029	-697,801	59,228	53
54	05400	1,176,595		1,176,595	54
56	05600				56
60	06000	1,490,998	-25,000	1,465,998	60
62.30	06250				62.30
65	06500	524,616		524,616	65
66	06600	163,701		163,701	66
69	06900	84,356		84,356	69
70	07000	62,440	-62,440		70
70.50	03951	14,647		14,647	70.50
71	07100	920,657		920,657	71
72	07200	169,876		169,876	72
73	07300	1,358,505	-13,543	1,344,962	73
76	03950				76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	1,182,843	-397,269	785,574	90
91	09100	1,308,434	-757,328	551,106	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		25,343,567	-3,457,226	21,886,341	118
NONREIMBURSABLE COST CENTERS					
192	19200	1,000,921		1,000,921	192
194	07950	100,271		100,271	194
200		26,444,759	-3,457,226	22,987,533	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 RECLASS CAFETERIA COSTS	A	CAFETERIA	11		108,831	150,708 1
500 TOTAL RECLASSIFICATIONS					108,831	150,708 500
CODE LETTER - A						
1 RECLASS SUPPLY COSTS	B	MEDICAL SUPPLIES CHRGED TO PA	71			1,090,533 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
500 TOTAL RECLASSIFICATIONS						1,090,533 500
CODE LETTER - B						
1 RECLASS DEPRECIATION EXPENSE	C	CAP REL COSTS-MVBLE EQUIP	2			972,833 1
500 TOTAL RECLASSIFICATIONS						972,833 500
CODE LETTER - C						
1 RECLASS SLEEP STUDY COSTS	D	SLEEP LAB	70.50		13,631	1,016 1
500 TOTAL RECLASSIFICATIONS					13,631	1,016 500
CODE LETTER - D						
1 RECLASS RADIOISOTOPE	E	RADIOLOGY-DIAGNOSTIC	54		91,744	52,313 1
500 TOTAL RECLASSIFICATIONS					91,744	52,313 500
CODE LETTER - E						
1 RECLASS INTEREST EXPENSE ON LEASES	F	CAP REL COSTS-MVBLE EQUIP	2			3,460 1
500 TOTAL RECLASSIFICATIONS						3,460 500
CODE LETTER - F						
1 RECLASS SUBSIDIARY COSTS	G	OTHER NONREIMBURSABLE	194		100,271	1
500 TOTAL RECLASSIFICATIONS					100,271	500
CODE LETTER - G						
1 RECLASS LAUNDRY EXPENSES	H	LAUNDRY & LINEN SERVICE	8			133,001 1
500 TOTAL RECLASSIFICATIONS						133,001 500
CODE LETTER - H						
1 RECLASS CLINIC DIRECTOR COSTS	I	PHYSICIANS' PRIVATE OFFICES	192		59,446	1
500 TOTAL RECLASSIFICATIONS					59,446	500
CODE LETTER - I						
1 RECLASS IMPLANT COSTS	J	IMPL. DEV. CHARGED TO PATIENT	72			169,876 1
500 TOTAL RECLASSIFICATIONS						169,876 500
CODE LETTER - J						
GRAND TOTAL (INCREASES)					373,923	2,573,740

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 RECLASS CAFETERIA COSTS	A	DIETARY	10	108,831	150,708	1
500 TOTAL RECLASSIFICATIONS				108,831	150,708	500
CODE LETTER - A						
1 RECLASS SUPPLY COSTS	B	ADULTS & PEDIATRICS	30		30,021	1
2 INTENSIVE CARE UNIT			31		7,808	2
3 OPERATING ROOM			50		848,474	3
4 RECOVERY ROOM			51		2,124	4
5 LABORATORY			60		50,052	5
6 ELECTROCARDIOLOGY			69		1,936	6
7 RADIOLOGY-DIAGNOSTIC			54		63,021	7
8 ANESTHESIOLOGY			53		18,458	8
9 RESPIRATORY THERAPY			65		19,249	9
10 PHYSICAL THERAPY			66		2,742	10
11 EMERGENCY			91		7,705	11
12 DRUGS CHARGED TO PATIENTS			73		28,276	12
13 CLINIC			90		10,667	13
500 TOTAL RECLASSIFICATIONS					1,090,533	500
CODE LETTER - B						
1 RECLASS DEPRECIATION EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		972,833	9 1
500 TOTAL RECLASSIFICATIONS					972,833	500
CODE LETTER - C						
1 RECLASS SLEEP STUDY COSTS	D	RESPIRATORY THERAPY	65	13,631	1,016	1
500 TOTAL RECLASSIFICATIONS				13,631	1,016	500
CODE LETTER - D						
1 RECLASS RADIOISOTOPE	E	RADIOISOTOPE	56	91,744	52,313	1
500 TOTAL RECLASSIFICATIONS				91,744	52,313	500
CODE LETTER - E						
1 RECLASS INTEREST EXPENSE ON LEASES	F	INTEREST EXPENSE	113		3,460	11 1
500 TOTAL RECLASSIFICATIONS					3,460	500
CODE LETTER - F						
1 RECLASS SUBSIDIARY COSTS	G	ADMINISTRATIVE & GENERAL	5.50	100,271		1
500 TOTAL RECLASSIFICATIONS				100,271		500
CODE LETTER - G						
1 RECLASS LAUNDRY EXPENSES	H	HOUSEKEEPING	9		133,001	1
500 TOTAL RECLASSIFICATIONS					133,001	500
CODE LETTER - H						
1 RECLASS CLINIC DIRECTOR COSTS	I	CLINIC	90	59,446		1
500 TOTAL RECLASSIFICATIONS				59,446		500
CODE LETTER - I						
1 RECLASS IMPLANT COSTS	J	MEDICAL SUPPLIES CHRGED TO PA	71		169,876	1
500 TOTAL RECLASSIFICATIONS					169,876	500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				373,923	2,573,740	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS	453,943					453,943		2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS	2,067,777	87,383		87,383	257,031	1,898,129		4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	9,483,426	1,590,532		1,590,532	14,865	11,059,093		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	12,005,146	1,677,915		1,677,915	271,896	13,411,165		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	12,005,146	1,677,915		1,677,915	271,896	13,411,165		10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,896,206						1,896,206 1
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)	1,896,206						1,896,206 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	2,352,072		2,352,072	0.175382				1
2 CAP REL COSTS-MVBLE EQUIP	11,059,093		11,059,093	0.824618				2
3 TOTAL (SUM OF LINES 1-2)	13,411,165		13,411,165	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	326,927						326,927 1
2 CAP REL COSTS-MVBLE EQUIP	795,711		2,863				798,574 2
3 TOTAL	1,122,638		2,863				1,125,501 3

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		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)	B	-597	CAP REL COSTS-MVBLE EQUIP	2	11 2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,813,316			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	-561,332			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-29,485	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	B	-13,543	DRUGS CHARGED TO PATIENTS	73	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-14,083	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES	B	-1,234	ADMINISTRATIVE & GENERAL	5.50	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		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES	A	-4,514	CAP REL COSTS-BLDG & FIXT	1	9 26
27 DEPRECIATION--MOVABLE EQUIPMENT	A	-177,122	CAP REL COSTS-MVBLE EQUIP	2	9 27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OFFSET SUPPORT SVCS COSTS	A	-148,208	ADULTS & PEDIATRICS	30	33
34 OFFSET CABLE TV COSTS	A	-3,177	ADMINISTRATIVE & GENERAL	5.50	34
35 OFFSET DONATIONS	A	-37,868	ADMINISTRATIVE & GENERAL	5.50	35
36 DUES OFFSET	A	-11,400	ADMINISTRATIVE & GENERAL	5.50	36
37 OFFSET MISCELLANEOUS INCOME	B	-5,669	ADMINISTRATIVE & GENERAL	5.50	37
38 OFFSET MARKETING COSTS/LOPEZ	A	-70,000	ADMINISTRATIVE & GENERAL	5.50	38
39 OFFSET CLINIC RENT EXPENSE	A	-30,600	CAP REL COSTS-BLDG & FIXT	1	9 39
40 OFFSET CLINIC PHYS MALP COST	A	-75,035	ADMINISTRATIVE & GENERAL	5.50	40
41 OFFSET MISC AG EXPENSES	A	-131,935	ADMINISTRATIVE & GENERAL	5.50	41
42 OFFSET GAIN ON SALE OF ASSETS	B	-5,603	ADMINISTRATIVE & GENERAL	5.50	42
43 OFFSET PENALTY COSTS	A	-2,551	ADMINISTRATIVE & GENERAL	5.50	43
43.01 OFFSET DENTIST COSTS	A	-754	ADMINISTRATIVE & GENERAL	5.50	43.01
43.05 OFFSET PHYS BILLING COSTS--ANEST	A	-17,296	ANESTHESIOLOGY	53	43.05
43.06 OFFSET PHYS BILLING COSTS--ER DOCS	A	-5,372	EMERGENCY	91	43.06
43.07 OFFSET UROLOGIST'S EXPENSE	A	-24,000	ADMINISTRATIVE & GENERAL	5.50	43.07
44 OFFSET PHYS BILLING COSTS--GOLDEN	A	-72,554	CLINIC	90	44
45 OFFSET ER PHYS MALP COST	A	-75,000	ADMINISTRATIVE & GENERAL	5.50	45
46 OFFSET NONALLOWABLE COSTS	A	-12,849	ADMINISTRATIVE & GENERAL	5.50	46
47 OFFSET GRANT REVENUE	B	-42,829	ADMINISTRATIVE & GENERAL	5.50	47
48 OFFSET SALARIED PHYSICIAN	A	-69,300	CLINIC	90	48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-3,457,226			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	CAP REL COSTS-BLDG & FIXT DEPRECIATION	38,668	600,000	-561,332	9
2						2
3						3
4						4
5		TOTALS (SUM OF LINES 1-4)	38,668	600,000	-561,332	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.

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----						
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	B WESTSIDE PARTNERSHIP	100.00				6
7						7
8						8
9						9
10						10

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	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	
1 60	LABORATORY	AGGREGATE	25,000	25,000					1
2 90	CLINIC	AGGREGATE	130,415	130,415					2
3 91	EMERGENCY	AGGREGATE	751,956	751,956					3
4 53	ANESTHESIOLOGY	AGGREGATE	680,505	680,505					4
5 90	CLINIC	SALARIED PHYSIC	125,000	125,000					5
6 21	I&R SRVCES-SALARY & FRIN	AGGREGATE	78,000	38,000	40,000	125,000	1,188	71,394	3,570 6
7 70	ELECTROENCEPHALOGRAPHY	AGGREGATE	62,440	62,440					7
200	TOTAL		1,853,316	1,813,316	40,000		1,188	71,394	3,570 200

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
 11/20/2012 10:36

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	60 LABORATORY	AGGREGATE						25,000	1
2	90 CLINIC	AGGREGATE						130,415	2
3	91 EMERGENCY	AGGREGATE						751,956	3
4	53 ANESTHESIOLOGY	AGGREGATE						680,505	4
5	90 CLINIC	SALARIED PHYSIC						125,000	5
6	21 I&R SRVCES-SALARY & FRIN	AGGREGATE				71,394		38,000	6
7	70 ELECTROENCEPHALOGRAPHY	AGGREGATE						62,440	7
200	TOTAL					71,394		1,813,316	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONES 5.10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	326,927	326,927				1
2 CAP REL COSTS-MVBLE EQUIP	798,574		798,574			2
4 EMPLOYEE BENEFITS	1,490,024	1,477	3,607	1,495,108		4
5.10 NONPATIENT TELEPHONES	188,072			5,307	193,379	5.10
5.20 DATA PROCESSING	322,427			17,408	3,022	5.20
5.30 PURCHASING	172,476	4,854	11,858	11,988	4,029	5.30
5.40 CASHIERING	719,010	5,814	14,202	72,558	8,057	5.40
5.50 ADMINISTRATIVE & GENERAL	2,390,614	22,309	54,495	167,343	43,310	5.50
6 MAINTENANCE & REPAIRS	375,323			23,403	6,043	6
7 OPERATION OF PLANT	859,069	54,629	133,441		1,007	7
8 LAUNDRY & LINEN SERVICE	133,001					8
9 HOUSEKEEPING	345,644	4,842	11,828	29,975	2,014	9
10 DIETARY	491,243	12,994	31,741	26,340	7,050	10
11 CAFETERIA	230,054	7,925	19,357	13,916		11
13 NURSING ADMINISTRATION	300,626	6,177	15,089	31,764	3,022	13
14 CENTRAL SERVICES & SUPPLY	290,109	8,921	21,792	9,877	4,029	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	295,732	14,699	35,904	23,558	12,086	16
17 SOCIAL SERVICE	50,667	886	2,164	5,987	4,029	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	270,088	1,760	4,298	24,052	8,057	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,518,639	79,026	193,031	282,272	14,101	30
31 INTENSIVE CARE UNIT	964,824	8,878	21,687	111,665	5,036	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	964,956	25,890	63,241	97,418	7,050	50
51 RECOVERY ROOM	126,926	1,975	4,824	15,106	2,014	51
53 ANESTHESIOLOGY	59,228	868	2,119	6,787	3,022	53
54 RADIOLOGY-DIAGNOSTIC	1,176,595	15,277	37,317	94,412	8,057	54
56 RADIOISOTOPE						56
60 LABORATORY	1,465,998	9,967	24,347	79,935	7,050	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	524,616	2,929	7,154	43,716	8,057	65
66 PHYSICAL THERAPY	163,701	7,568	18,486	18,194	3,022	66
69 ELECTROCARDIOLOGY	84,356	2,867	7,003	9,341	4,029	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	14,647	615	1,503	1,743		70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	920,657					71
72 IMPL. DEV. CHARGED TO PATIENT	169,876					72
73 DRUGS CHARGED TO PATIENTS	1,344,962	1,920	4,689	41,583	6,043	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	785,574	15,308	37,392	94,217	12,086	90
91 EMERGENCY	551,106	3,476	8,491	63,868	8,057	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	21,886,341	323,851	791,060	1,423,733	193,379	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,000,921			58,554		192
194 OTHER NONREIMBURSABLE	100,271	3,076	7,514	12,821		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	22,987,533	326,927	798,574	1,495,108	193,379	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCESSING 5.20	PURCHASING 5.30	CASHIERING 5.40	SUBTOTAL (COLS.0-4) 4A	ADMIN AND GENERAL 5.50	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING	342,857					5.20
5.30 PURCHASING		205,205				5.30
5.40 CASHIERING	171,428	3,043	994,112			5.40
5.50 ADMINISTRATIVE & GENERAL	34,286	4,333		2,716,690	2,716,690	5.50
6 MAINTENANCE & REPAIRS		8,163		412,932	55,341	6
7 OPERATION OF PLANT		47		1,048,193	140,479	7
8 LAUNDRY & LINEN SERVICE				133,001	17,825	8
9 HOUSEKEEPING		4,716		399,019	53,477	9
10 DIETARY		5,394		574,762	77,030	10
11 CAFETERIA				271,252	36,353	11
13 NURSING ADMINISTRATION		874		357,552	47,919	13
14 CENTRAL SERVICES & SUPPLY				334,728	44,860	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	34,286	518		416,783	55,857	16
17 SOCIAL SERVICE		42		63,775	8,547	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD		676		308,931	41,403	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		11,619	227,686	3,326,374	445,793	30
31 INTENSIVE CARE UNIT		3,022	37,083	1,152,195	154,417	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		91,224	61,740	1,311,519	175,770	50
51 RECOVERY ROOM		228	21,300	172,373	23,101	51
53 ANESTHESIOLOGY		2,381	55,552	129,957	17,417	53
54 RADIOLOGY-DIAGNOSTIC		8,130	92,814	1,432,602	191,997	54
56 RADIOISOTOPE						56
60 LABORATORY		19,373	152,434	1,759,104	235,755	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		7,450	38,413	632,335	84,746	65
66 PHYSICAL THERAPY		1,061	7,453	219,485	29,415	66
69 ELECTROCARDIOLOGY		749	38,890	147,235	19,732	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB			2,423	20,931	2,805	70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		18,784	40,877	980,318	131,382	71
72 IMPL. DEV. CHARGED TO PATIENT			7,450	177,326	23,765	72
73 DRUGS CHARGED TO PATIENTS		3,648	148,644	1,551,489	207,931	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	68,571	4,129	13,490	1,030,767	138,143	90
91 EMERGENCY	34,286	2,982	47,863	720,129	96,512	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	342,857	202,586	994,112	21,801,757	2,557,772	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		2,619		1,062,094	142,342	192
194 OTHER NONREIMBURSABLE				123,682	16,576	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	342,857	205,205	994,112	22,987,533	2,716,690	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	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
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING						5.20
5.30 PURCHASING						5.30
5.40 CASHIERING						5.40
5.50 ADMINISTRATIVE & GENERAL						5.50
6 MAINTENANCE & REPAIRS	468,273					6
7 OPERATION OF PLANT	87,466	1,276,138				7
8 LAUNDRY & LINEN SERVICE			150,826			8
9 HOUSEKEEPING	7,753	25,980		486,229		9
10 DIETARY	20,805	69,721		27,117	769,435	10
11 CAFETERIA	12,688	42,519		16,547		11
13 NURSING ADMINISTRATION	9,890	33,144		12,896		13
14 CENTRAL SERVICES & SUPPLY	14,284	47,867				14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	23,534	78,865		30,680		16
17 SOCIAL SERVICE	1,419	4,754		1,855		17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	2,817	9,441	1,508	3,680		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	127,510	427,304	100,170	164,914	672,385	30
31 INTENSIVE CARE UNIT	14,215	47,636	14,458	18,520	97,050	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	41,453	138,914	16,591	54,029		50
51 RECOVERY ROOM	3,162	10,597		4,122		51
53 ANESTHESIOLOGY	1,389	4,655		1,796		53
54 RADIOLOGY-DIAGNOSTIC	24,460	81,968	4,525	31,887		54
56 RADIOISOTOPE						56
60 LABORATORY	15,958	53,479		20,787		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	4,689	15,714		6,124		65
66 PHYSICAL THERAPY	12,117	40,605	1,508	15,782		66
69 ELECTROCARDIOLOGY	4,591	15,384		5,977		69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB				1,296		70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				18,608		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	3,073	10,300		4,004		73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	24,509	82,133	1,508	31,946		90
91 EMERGENCY	5,566	18,652	10,558	7,243		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	463,348	1,259,632	150,826	479,810	769,435	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NONREIMBURSABLE	4,925	16,506		6,419		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	468,273	1,276,138	150,826	486,229	769,435	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING						5.20
5.30 PURCHASING						5.30
5.40 CASHIERING						5.40
5.50 ADMINISTRATIVE & GENERAL						5.50
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	379,359					11
13 NURSING ADMINISTRATION	7,314	468,715				13
14 CENTRAL SERVICES & SUPPLY			441,739			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	11,642			617,361		16
17 SOCIAL SERVICE	2,739				83,089	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	16,436					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	83,712	198,227		244,195	74,780	30
31 INTENSIVE CARE UNIT	23,804	56,345				31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	34,022	53,709		123,388		50
51 RECOVERY ROOM	3,260	5,146				51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	30,926			67,804		54
56 RADIOISOTOPE						56
60 LABORATORY	38,486			29,817		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	18,983	31,006				65
66 PHYSICAL THERAPY	4,081			23,532		66
69 ELECTROCARDIOLOGY	4,903			10,963		69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	657					70.50
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	5,451		379,402			71
72 IMPL. DEV. CHARGED TO PATIENT			62,337			72
73 DRUGS CHARGED TO PATIENTS	14,217					73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	56,730	89,558		102,160	8,309	90
91 EMERGENCY	21,996	34,724		15,502		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	379,359	468,715	441,739	617,361	83,089	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NONREIMBURSABLE						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	379,359	468,715	441,739	617,361	83,089	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R SALARY & FRINGES 21	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.10 NONPATIENT TELEPHONES					5.10
5.20 DATA PROCESSING					5.20
5.30 PURCHASING					5.30
5.40 CASHIERING					5.40
5.50 ADMINISTRATIVE & GENERAL					5.50
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
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
21 I&R SRVCES-SALARY & FRINGES APPRVD	384,216				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	42,983	5,908,347	-42,983	5,865,364	30
31 INTENSIVE CARE UNIT		1,578,640		1,578,640	31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	298,426	2,247,821	-298,426	1,949,395	50
51 RECOVERY ROOM		221,761		221,761	51
53 ANESTHESIOLOGY	15,790	171,004	-15,790	155,214	53
54 RADIOLOGY-DIAGNOSTIC	10,877	1,877,046	-10,877	1,866,169	54
56 RADIOISOTOPE					56
60 LABORATORY	5,263	2,158,649	-5,263	2,153,386	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		793,597		793,597	65
66 PHYSICAL THERAPY		346,525		346,525	66
69 ELECTROCARDIOLOGY		208,785		208,785	69
70 ELECTROENCEPHALOGRAPHY					70
70.50 SLEEP LAB		25,689		25,689	70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,515,161		1,515,161	71
72 IMPL. DEV. CHARGED TO PATIENT		263,428		263,428	72
73 DRUGS CHARGED TO PATIENTS		1,791,014		1,791,014	73
76 INDUSTRIAL MEDICINE					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		1,565,763		1,565,763	90
91 EMERGENCY	10,877	941,759	-10,877	930,882	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	384,216	21,614,989	-384,216	21,230,773	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES		1,204,436		1,204,436	192
194 OTHER NONREIMBURSABLE		168,108		168,108	194
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	384,216	22,987,533	-384,216	22,603,317	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		1,477	3,607	5,084	5,084	4
5.10	NONPATIENT TELEPHONES						18
5.20	DATA PROCESSING						59
5.30	PURCHASING		4,854	11,858	16,712		41
5.40	CASHIERING		5,814	14,202	20,016		247
5.50	ADMINISTRATIVE & GENERAL		22,309	54,495	76,804		569
6	MAINTENANCE & REPAIRS						80
7	OPERATION OF PLANT		54,629	133,441	188,070		
8	LAUNDRY & LINEN SERVICE						
9	HOUSEKEEPING		4,842	11,828	16,670		102
10	DIETARY		12,994	31,741	44,735		90
11	CAFETERIA		7,925	19,357	27,282		47
13	NURSING ADMINISTRATION		6,177	15,089	21,266		108
14	CENTRAL SERVICES & SUPPLY		8,921	21,792	30,713		34
15	PHARMACY						
16	MEDICAL RECORDS & LIBRARY		14,699	35,904	50,603		80
17	SOCIAL SERVICE		886	2,164	3,050		20
19	NONPHYSICIAN ANESTHETISTS						
21	I&R SRVCES-SALARY & FRINGES APPRVD		1,760	4,298	6,058		82
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						
23	PARAMED ED PRGM-(SPECIFY)						
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		79,026	193,031	272,057		958
31	INTENSIVE CARE UNIT		8,878	21,687	30,565		380
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		25,890	63,241	89,131		331
51	RECOVERY ROOM		1,975	4,824	6,799		51
53	ANESTHESIOLOGY		868	2,119	2,987		23
54	RADIOLOGY-DIAGNOSTIC		15,277	37,317	52,594		321
56	RADIOISOTOPE						
60	LABORATORY		9,967	24,347	34,314		272
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						
65	RESPIRATORY THERAPY		2,929	7,154	10,083		149
66	PHYSICAL THERAPY		7,568	18,486	26,054		62
69	ELECTROCARDIOLOGY		2,867	7,003	9,870		32
70	ELECTROENCEPHALOGRAPHY						
70.50	SLEEP LAB		615	1,503	2,118		6
71	MEDICAL SUPPLIES CHRGD TO PATIENTS						
72	IMPL. DEV. CHARGED TO PATIENT						
73	DRUGS CHARGED TO PATIENTS		1,920	4,689	6,609		141
76	INDUSTRIAL MEDICINE						
76.97	CARDIAC REHABILITATION						
76.98	HYPERBARIC OXYGEN THERAPY						
76.99	LITHOTRIPSY						
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC		15,308	37,392	52,700		321
91	EMERGENCY		3,476	8,491	11,967		217
92	OBSERVATION BEDS						
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						
118	SUBTOTALS (SUM OF LINES 1-117)		323,851	791,060	1,114,911	4,841	118
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES						199
194	OTHER NONREIMBURSABLE		3,076	7,514	10,590		44
200	CROSS FOOT ADJUSTMENTS						
201	NEGATIVE COST CENTER						
202	TOTAL (SUM OF LINES 118-201)		326,927	798,574	1,125,501	5,084	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NONPATIENT	DATA	PURCHASING	CASHIERING	ADMIN	
	TELEPHONES	PROCESSING			AND GENERAL	
	5.10	5.20	5.30	5.40	5.50	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES	18					5.10
5.20 DATA PROCESSING		59				5.20
5.30 PURCHASING			16,753			5.30
5.40 CASHIERING	1	29	248	20,541		5.40
5.50 ADMINISTRATIVE & GENERAL	5	6	354		77,738	5.50
6 MAINTENANCE & REPAIRS	1		666		1,584	6
7 OPERATION OF PLANT			4		4,020	7
8 LAUNDRY & LINEN SERVICE					510	8
9 HOUSEKEEPING			385		1,530	9
10 DIETARY	1		440		2,204	10
11 CAFETERIA					1,040	11
13 NURSING ADMINISTRATION			71		1,371	13
14 CENTRAL SERVICES & SUPPLY					1,284	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1	6	42		1,598	16
17 SOCIAL SERVICE			3		245	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	1		55		1,185	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1		949	4,699	12,755	30
31 INTENSIVE CARE UNIT			247	767	4,419	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1		7,448	1,276	5,030	50
51 RECOVERY ROOM			19	440	661	51
53 ANESTHESIOLOGY			194	1,148	498	53
54 RADIOLOGY-DIAGNOSTIC	1		664	1,918	5,494	54
56 RADIOISOTOPE						56
60 LABORATORY	1		1,582	3,151	6,746	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1		608	794	2,425	65
66 PHYSICAL THERAPY			87	154	842	66
69 ELECTROCARDIOLOGY			61	804	565	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB				50	80	70.50
71 MEDICAL SUPPLIES CHRGED TO PATIENTS			1,534	845	3,760	71
72 IMPL. DEV. CHARGED TO PATIENT				154	680	72
73 DRUGS CHARGED TO PATIENTS	1		298	3,073	5,950	73
76 INDUSTRIAL MEDICINE						76
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	12	337	279	3,953	90
91 EMERGENCY	1	6	243	989	2,762	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	18	59	16,539	20,541	73,191	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			214		4,073	192
194 OTHER NONREIMBURSABLE					474	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	18	59	16,753	20,541	77,738	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MAIN-	OPERATION	LAUNDRY	HOUSE-	DIETARY	
	TENANCE & REPAIRS 6	OF PLANT 7	& LINEN SERVICE 8	KEEPING 9	10	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5.10						5.10
5.20						5.20
5.30						5.30
5.40						5.40
5.50						5.50
6	2,331					6
7	435	192,529				7
8			510			8
9	39	3,920		22,646		9
10	104	10,519		1,263	59,356	10
11	63	6,415		771		11
13	49	5,000		601		13
14	71	7,222				14
15						15
16	117	11,898		1,429		16
17	7	717		86		17
19						19
21	14	1,424	5	171		21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	635	64,467	339	7,682	51,869	30
31	71	7,187	49	863	7,487	31
ANCILLARY SERVICE COST CENTERS						
50	206	20,958	56	2,516		50
51	16	1,599		192		51
53	7	702		84		53
54	122	12,366	15	1,485		54
56						56
60	79	8,068		968		60
62.30						62.30
65	23	2,371		285		65
66	60	6,126	5	735		66
69	23	2,321		278		69
70						70
70.50				60		70.50
71				867		71
72						72
73	15	1,554		186		73
76						76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
90	122	12,391	5	1,488		90
91	28	2,814	36	337		91
92						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113						113
118	2,306	190,039	510	22,347	59,356	118
NONREIMBURSABLE COST CENTERS						
192						192
194	25	2,490		299		194
200						200
201						201
202	2,331	192,529	510	22,646	59,356	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING						5.20
5.30 PURCHASING						5.30
5.40 CASHIERING						5.40
5.50 ADMINISTRATIVE & GENERAL						5.50
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	35,618					11
13 NURSING ADMINISTRATION	687	29,153				13
14 CENTRAL SERVICES & SUPPLY			39,324			14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,093			66,867		16
17 SOCIAL SERVICE	257				4,385	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	1,543					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	7,861	12,328		26,449	3,946	30
31 INTENSIVE CARE UNIT	2,235	3,505				31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,194	3,341		13,364		50
51 RECOVERY ROOM	306	320				51
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,904			7,344		54
56 RADIOISOTOPE						56
60 LABORATORY	3,613			3,230		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,782	1,929				65
66 PHYSICAL THERAPY	383			2,549		66
69 ELECTROCARDIOLOGY	460			1,187		69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	62					70.50
71 MEDICAL SUPPLIES CHRGED TO PATIENTS	512		33,775			71
72 IMPL. DEV. CHARGED TO PATIENT			5,549			72
73 DRUGS CHARGED TO PATIENTS	1,335					73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	5,326	5,570		11,065	439	90
91 EMERGENCY	2,065	2,160		1,679		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	35,618	29,153	39,324	66,867	4,385	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NONREIMBURSABLE						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35,618	29,153	39,324	66,867	4,385	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R SALARY & FRINGES 21	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.10 NONPATIENT TELEPHONES					5.10
5.20 DATA PROCESSING					5.20
5.30 PURCHASING					5.30
5.40 CASHIERING					5.40
5.50 ADMINISTRATIVE & GENERAL					5.50
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
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
21 I&R SRVCES-SALARY & FRINGES APPRVD	10,538				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		466,995		466,995	30
31 INTENSIVE CARE UNIT		57,775		57,775	31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		146,852		146,852	50
51 RECOVERY ROOM		10,403		10,403	51
53 ANESTHESIOLOGY		5,643		5,643	53
54 RADIOLOGY-DIAGNOSTIC		85,228		85,228	54
56 RADIOISOTOPE					56
60 LABORATORY		62,024		62,024	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		20,450		20,450	65
66 PHYSICAL THERAPY		37,057		37,057	66
69 ELECTROCARDIOLOGY		15,601		15,601	69
70 ELECTROENCEPHALOGRAPHY					70
70.50 SLEEP LAB		2,376		2,376	70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		41,293		41,293	71
72 IMPL. DEV. CHARGED TO PATIENT		6,383		6,383	72
73 DRUGS CHARGED TO PATIENTS		19,162		19,162	73
76 INDUSTRIAL MEDICINE					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC		94,009		94,009	90
91 EMERGENCY		25,304		25,304	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)		1,096,555		1,096,555	118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES		4,486		4,486	192
194 OTHER NONREIMBURSABLE		13,922		13,922	194
200 CROSS FOOT ADJUSTMENTS	10,538	10,538		10,538	200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	10,538	1,125,501		1,125,501	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	NONPATIENT TELEPHONES NUMBER OF PHONES	DATA PROCESSING TIME SPENT	
	1	2	4	5.10	5.20	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	53,136					1
2 CAP REL COSTS-MVBLE EQUIP		53,136				2
4 EMPLOYEE BENEFITS	240	240	11,692,578			4
5.10 NONPATIENT TELEPHONES			41,507	192		5.10
5.20 DATA PROCESSING			136,143	3	100	5.20
5.30 PURCHASING	789	789	93,755	4		5.30
5.40 CASHIERING	945	945	567,445	8	50	5.40
5.50 ADMINISTRATIVE & GENERAL	3,626	3,626	1,308,720	43	10	5.50
6 MAINTENANCE & REPAIRS			183,028	6		6
7 OPERATION OF PLANT	8,879	8,879		1		7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	787	787	234,420	2		9
10 DIETARY	2,112	2,112	205,990	7		10
11 CAFETERIA	1,288	1,288	108,831			11
13 NURSING ADMINISTRATION	1,004	1,004	248,413	3		13
14 CENTRAL SERVICES & SUPPLY	1,450	1,450	77,241	4		14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	2,389	2,389	184,238	12	10	16
17 SOCIAL SERVICE	144	144	46,818	4		17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	286	286	188,102	8		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,844	12,844	2,207,512	14		30
31 INTENSIVE CARE UNIT	1,443	1,443	873,280	5		31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,208	4,208	761,866	7		50
51 RECOVERY ROOM	321	321	118,136	2		51
53 ANESTHESIOLOGY	141	141	53,075	3		53
54 RADIOLOGY-DIAGNOSTIC	2,483	2,483	738,356	8		54
56 RADIOISOTOPE						56
60 LABORATORY	1,620	1,620	625,137	7		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	476	476	341,883	8		65
66 PHYSICAL THERAPY	1,230	1,230	142,288	3		66
69 ELECTROCARDIOLOGY	466	466	73,051	4		69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	100	100	13,631			70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS	312	312	325,205	6		73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,488	2,488	736,827	12	20	90
91 EMERGENCY	565	565	499,486	8	10	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	52,636	52,636	11,134,384	192	100	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			457,923			192
194 OTHER NONREIMBURSABLE	500	500	100,271			194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	326,927	798,574	1,495,108	193,379	342,857	202
203 UNIT COST MULT-WS B PT I	6.152646	15.028869	0.127868	1,007.182292	3,428.570000	203
204 COST TO BE ALLOC PER B PT II			5,084	18	59	204
205 UNIT COST MULT-WS B PT II			0.000435	0.093750	0.590000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING	CASHIERING	RECON-	ADMIN	MAIN-	
	COST OF REQUISITION 5.30	GROSS REVENUE 5.40	CILIIATION 5A.50	AND GENERAL ACCUM COST 5.50	TENANCE & REPAIRS SQUARE FEET 6	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING						5.20
5.30 PURCHASING	2,120,724					5.30
5.40 CASHIERING	31,445	79,341,072				5.40
5.50 ADMINISTRATIVE & GENERAL	44,783		-2,716,690	20,270,843		5.50
6 MAINTENANCE & REPAIRS	84,362			412,932	47,536	6
7 OPERATION OF PLANT	483			1,048,193	8,879	7
8 LAUNDRY & LINEN SERVICE				133,001		8
9 HOUSEKEEPING	48,737			399,019	787	9
10 DIETARY	55,750			574,762	2,112	10
11 CAFETERIA				271,252	1,288	11
13 NURSING ADMINISTRATION	9,030			357,552	1,004	13
14 CENTRAL SERVICES & SUPPLY				334,728	1,450	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	5,356			416,783	2,389	16
17 SOCIAL SERVICE	431			63,775	144	17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD	6,989			308,931	286	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	120,082	18,173,853		3,326,374	12,944	30
31 INTENSIVE CARE UNIT	31,230	2,959,500		1,152,195	1,443	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	942,749	4,927,406		1,311,519	4,208	50
51 RECOVERY ROOM	2,360	1,699,960		172,373	321	51
53 ANESTHESIOLOGY	24,611	4,433,521		129,957	141	53
54 RADIOLOGY-DIAGNOSTIC	84,025	7,407,309		1,432,602	2,483	54
56 RADIOISOTOPE						56
60 LABORATORY	200,209	12,165,559		1,759,104	1,620	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	76,995	3,065,669		632,335	476	65
66 PHYSICAL THERAPY	10,969	594,789		219,485	1,230	66
69 ELECTROCARDIOLOGY	7,745	3,103,752		147,235	466	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB		193,360		20,931		70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	194,130	3,262,293		980,318		71
72 IMPL. DEV. CHARGED TO PATIENT		594,566		177,326		72
73 DRUGS CHARGED TO PATIENTS	37,702	11,863,017		1,551,489	312	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	42,667	1,076,614		1,030,767	2,488	90
91 EMERGENCY	30,818	3,819,904		720,129	565	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	2,093,658	79,341,072	-2,716,690	19,085,067	47,036	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	27,066			1,062,094		192
194 OTHER NONREIMBURSABLE				123,682	500	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	205,205	994,112		2,716,690	468,273	202
203 UNIT COST MULT-WS B PT I	0.096762	0.012530		0.134020	9.850913	203
204 COST TO BE ALLOC PER B PT II	16,753	20,541		77,738	2,331	204
205 UNIT COST MULT-WS B PT II	0.007900	0.000259		0.003835	0.049037	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA
	OF PLANT	& LINEN	KEEPING		
	SQUARE	SERVICE	HOURS OF	MEALS	FTES
	FEET	POUNDS OF	SERVICE	SERVED	
	7	LAUNDRY	9	10	11
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.10 NONPATIENT TELEPHONES					5.10
5.20 DATA PROCESSING					5.20
5.30 PURCHASING					5.30
5.40 CASHIERING					5.40
5.50 ADMINISTRATIVE & GENERAL					5.50
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	38,657				7
8 LAUNDRY & LINEN SERVICE		189,728			8
9 HOUSEKEEPING	787		16,514		9
10 DIETARY	2,112		921	53,603	10
11 CAFETERIA	1,288		562		13,849
13 NURSING ADMINISTRATION	1,004		438		267
14 CENTRAL SERVICES & SUPPLY	1,450				
15 PHARMACY					
16 MEDICAL RECORDS & LIBRARY	2,389		1,042		425
17 SOCIAL SERVICE	144		63		100
19 NONPHYSICIAN ANESTHETISTS					
21 I&R SRVCES-SALARY & FRINGES APPRVD	286	1,897	125		600
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					
23 PARAMED ED PRGM-(SPECIFY)					
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	12,944	126,007	5,601	46,842	3,056
31 INTENSIVE CARE UNIT	1,443	18,187	629	6,761	869
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	4,208	20,870	1,835		1,242
51 RECOVERY ROOM	321		140		119
53 ANESTHESIOLOGY	141		61		
54 RADIOLOGY-DIAGNOSTIC	2,483	5,692	1,083		1,129
56 RADIOISOTOPE					
60 LABORATORY	1,620		706		1,405
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					
65 RESPIRATORY THERAPY	476		208		693
66 PHYSICAL THERAPY	1,230	1,897	536		149
69 ELECTROCARDIOLOGY	466		203		179
70 ELECTROENCEPHALOGRAPHY					
70.50 SLEEP LAB			44		24
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			632		199
72 IMPL. DEV. CHARGED TO PATIENT					
73 DRUGS CHARGED TO PATIENTS	312		136		519
76 INDUSTRIAL MEDICINE					
76.97 CARDIAC REHABILITATION					
76.98 HYPERBARIC OXYGEN THERAPY					
76.99 LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	2,488	1,897	1,085		2,071
91 EMERGENCY	565	13,281	246		803
92 OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	38,157	189,728	16,296	53,603	13,849
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					
194 OTHER NONREIMBURSABLE	500		218		
200 CROSS FOOT ADJUSTMENTS					
201 NEGATIVE COST CENTER					
202 COST TO BE ALLOC PER B PT I	1,276,138	150,826	486,229	769,435	379,359
203 UNIT COST MULT-WS B PT I	33.011822	0.794959	29.443442	14.354327	27.392519
204 COST TO BE ALLOC PER B PT II	192,529	510	22,646	59,356	35,618
205 UNIT COST MULT-WS B PT II	4.980443	0.002688	1.371321	1.107326	2.571882

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSNG HRS 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	I&R SALARY & FRINGES ASSIGNED TIME 21	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.10 NONPATIENT TELEPHONES						5.10
5.20 DATA PROCESSING						5.20
5.30 PURCHASING						5.30
5.40 CASHIERING						5.40
5.50 ADMINISTRATIVE & GENERAL						5.50
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	225,451					13
14 CENTRAL SERVICES & SUPPLY		1,090,533				14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY			8,841			16
17 SOCIAL SERVICE				100		17
19 NONPHYSICIAN ANESTHETISTS						19
21 I&R SRVCES-SALARY & FRINGES APPRVD					2,190	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	95,347		3,497	90	245	30
31 INTENSIVE CARE UNIT	27,102					31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	25,834		1,767		1,701	50
51 RECOVERY ROOM	2,475					51
53 ANESTHESIOLOGY					90	53
54 RADIOLOGY-DIAGNOSTIC			971		62	54
56 RADIOISOTOPE						56
60 LABORATORY			427		30	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	14,914					65
66 PHYSICAL THERAPY			337			66
69 ELECTROCARDIOLOGY			157			69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB						70.50
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		936,641				71
72 IMPL. DEV. CHARGED TO PATIENT		153,892				72
73 DRUGS CHARGED TO PATIENTS						73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	43,077		1,463	10		90
91 EMERGENCY	16,702		222		62	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	225,451	1,090,533	8,841	100	2,190	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NONREIMBURSABLE						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	468,715	441,739	617,361	83,089	384,216	202
203 UNIT COST MULT-WS B PT I	2.079011	0.405067	69.829318	830.890000	175.441096	203
204 COST TO BE ALLOC PER B PT II	29,153	39,324	66,867	4,385	10,538	204
205 UNIT COST MULT-WS B PT II	0.129310	0.036059	7.563285	43.850000	4.811872	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
5.10	NONPATIENT TELEPHONES	5.10
5.20	DATA PROCESSING	5.20
5.30	PURCHASING	5.30
5.40	CASHIERING	5.40
5.50	ADMINISTRATIVE & GENERAL	5.50
6	MAINTENANCE & REPAIRS	6
7	OPERATION OF PLANT	7
8	LAUNDRY & LINEN SERVICE	8
9	HOUSEKEEPING	9
10	DIETARY	10
11	CAFETERIA	11
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
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
51	RECOVERY ROOM	51
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
56	RADIOISOTOPE	56
60	LABORATORY	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
69	ELECTROCARDIOLOGY	69
70	ELECTROENCEPHALOGRAPHY	70
70.50	SLEEP LAB	70.50
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76	INDUSTRIAL MEDICINE	76
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
91	EMERGENCY	91
92	OBSERVATION BEDS	92
OTHER REIMBURSABLE COST CENTERS		
SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS		
192	PHYSICIANS' PRIVATE OFFICES	192
194	OTHER NONREIMBURSABLE	194
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	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,865,364		5,865,364		5,865,364	30
31 INTENSIVE CARE UNIT	1,578,640		1,578,640		1,578,640	31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,949,395		1,949,395		1,949,395	50
51 RECOVERY ROOM	221,761		221,761		221,761	51
53 ANESTHESIOLOGY	155,214		155,214		155,214	53
54 RADIOLOGY-DIAGNOSTIC	1,866,169		1,866,169		1,866,169	54
56 RADIOISOTOPE						56
60 LABORATORY	2,153,386		2,153,386		2,153,386	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	793,597		793,597		793,597	65
66 PHYSICAL THERAPY	346,525		346,525		346,525	66
69 ELECTROCARDIOLOGY	208,785		208,785		208,785	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	25,689		25,689		25,689	70.50
71 MEDICAL SUPPLIES CHRGD TO	1,515,161		1,515,161		1,515,161	71
72 IMPL. DEV. CHARGED TO PATIE	263,428		263,428		263,428	72
73 DRUGS CHARGED TO PATIENTS	1,791,014		1,791,014		1,791,014	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	1,565,763		1,565,763		1,565,763	90
91 EMERGENCY	930,882		930,882		930,882	91
92 OBSERVATION BEDS	127,853		127,853		127,853	92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	21,358,626		21,358,626		21,358,626	200
201 LESS OBSERVATION BEDS	127,853		127,853		127,853	201
202 TOTAL (SEE INSTRUCTIONS)	21,230,773		21,230,773		21,230,773	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	17,709,956		17,709,956			30
31 INTENSIVE CARE UNIT	2,959,500		2,959,500			31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,656,151	3,271,255	4,927,406	0.395623	0.395623	0.395623 50
51 RECOVERY ROOM	400,559	1,299,401	1,699,960	0.130451	0.130451	0.130451 51
53 ANESTHESIOLOGY	1,496,645	2,936,876	4,433,521	0.035009	0.035009	0.035009 53
54 RADIOLOGY-DIAGNOSTIC	2,550,726	4,856,583	7,407,309	0.251936	0.251936	0.251936 54
56 RADIOISOTOPE						56
60 LABORATORY	6,223,171	5,942,388	12,165,559	0.177007	0.177007	0.177007 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,909,400	156,269	3,065,669	0.258866	0.258866	0.258866 65
66 PHYSICAL THERAPY	335,700	259,089	594,789	0.582602	0.582602	0.582602 66
69 ELECTROCARDIOLOGY	1,657,426	1,446,326	3,103,752	0.067269	0.067269	0.067269 69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	2,594	190,766	193,360	0.132856	0.132856	0.132856 70.50
71 MEDICAL SUPPLIES CHRGD TO	1,702,725	1,559,568	3,262,293	0.464447	0.464447	0.464447 71
72 IMPL. DEV. CHARGED TO PATIE	363,406	231,160	594,566	0.443059	0.443059	0.443059 72
73 DRUGS CHARGED TO PATIENTS	10,355,889	1,507,128	11,863,017	0.150975	0.150975	0.150975 73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	17,474	1,059,140	1,076,614	1.454340	1.454340	1.454340 90
91 EMERGENCY	676,762	3,143,142	3,819,904	0.243693	0.243693	0.243693 91
92 OBSERVATION BEDS	22,229	441,668	463,897	0.275606	0.275606	0.275606 92
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	51,040,313	28,300,759	79,341,072			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	51,040,313	28,300,759	79,341,072			202

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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		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED 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	466,995		466,995	14,038	33.27	5,188	172,605	30
31 INTENSIVE CARE UNIT	57,775		57,775	1,982	29.15	1,098	32,007	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)	524,770		524,770	16,020		6,286	204,612	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0151) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

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	146,852	4,927,406	0.029803	878,868	26,193	50
51 RECOVERY ROOM	10,403	1,699,960	0.006120	226,736	1,388	51
53 ANESTHESIOLOGY	5,643	4,433,521	0.001273	795,074	1,012	53
54 RADIOLOGY-DIAGNOSTIC	85,228	7,407,309	0.011506	1,528,068	17,582	54
56 RADIOISOTOPE						56
60 LABORATORY	62,024	12,165,559	0.005098	3,282,076	16,732	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	20,450	3,065,669	0.006671	1,686,851	11,253	65
66 PHYSICAL THERAPY	37,057	594,789	0.062303	211,813	13,197	66
69 ELECTROCARDIOLOGY	15,601	3,103,752	0.005026	975,472	4,903	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	2,376	193,360	0.012288			70.50
71 MEDICAL SUPPLIES CHRGED TO PA	41,293	3,262,293	0.012658	954,349	12,080	71
72 IMPL. DEV. CHARGED TO PATIENT	6,383	594,566	0.010736	214,227	2,300	72
73 DRUGS CHARGED TO PATIENTS	19,162	11,863,017	0.001615	5,179,170	8,364	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	94,009	1,076,614	0.087319	6,877	600	90
91 EMERGENCY	25,304	3,819,904	0.006624	337,355	2,235	91
92 OBSERVATION BEDS	10,180	463,897	0.021945	18,223	400	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	581,965	58,671,616		16,295,159	118,239	200

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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
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

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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	PER DIEM	INPATIENT	INPAT PGM
	PATIENT DAYS 6	COL.5 ÷ COL.6) 7	PROGRAM DAYS 8	PASS THRU COSTS (COL.7 x COL.8) 9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	14,038		5,188	30
31 INTENSIVE CARE UNIT	1,982		1,098	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)	16,020		6,286	200

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-0151)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[]	TITLE XIX	[]	IRF	[]	NF				

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN					
	ANESTHETIST			EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM					50
51	RECOVERY ROOM					51
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC					54
56	RADIOISOTOPE					56
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
69	ELECTROCARDIOLOGY					69
70	ELECTROENCEPHALOGRAPHY					70
70.50	SLEEP LAB					70.50
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
76	INDUSTRIAL MEDICINE					76
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
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 (14-0151)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM PASS-THRU COSTS		
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 + COL. 7)	(COL. 6 + COL. 7)	INPAT PGM CHARGES COL. 10)	(COL. 8 x COL. 10) O/P PGM CHARGES COL. 12)	(COL. 9 x COL. 12)	
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	4,927,406			878,868		1,471,308	50
51 RECOVERY ROOM	1,699,960			226,736		591,044	51
53 ANESTHESIOLOGY	4,433,521			795,074		1,315,709	53
54 RADIOLOGY-DIAGNOSTIC	7,407,309			1,528,068		2,259,870	54
56 RADIOISOTOPE							56
60 LABORATORY	12,165,559			3,282,076		203,259	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	3,065,669			1,686,851		71,480	65
66 PHYSICAL THERAPY	594,789			211,813			66
69 ELECTROCARDIOLOGY	3,103,752			975,472		849,018	69
70 ELECTROENCEPHALOGRAPHY							70
70.50 SLEEP LAB	193,360					143,484	70.50
71 MEDICAL SUPPLIES CHRGED TO P	3,262,293			954,349		735,766	71
72 IMPL. DEV. CHARGED TO PATIEN	594,566			214,227		205,093	72
73 DRUGS CHARGED TO PATIENTS	11,863,017			5,179,170		563,558	73
76 INDUSTRIAL MEDICINE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1,076,614			6,877		785,444	90
91 EMERGENCY	3,819,904			337,355		478,330	91
92 OBSERVATION BEDS	463,897			18,223		234,169	92
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	58,671,616			16,295,159		9,907,532	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0151) [] 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. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES DED & COINS	COST SERVICES 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	0.395623	1,471,308			582,083		50
51 RECOVERY ROOM	0.130451	591,044			77,102		51
53 ANESTHESIOLOGY	0.035009	1,315,709			46,062		53
54 RADIOLOGY-DIAGNOSTIC	0.251936	2,259,870			569,343		54
56 RADIOISOTOPE							56
60 LABORATORY	0.177007	203,259			35,978		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.258866	71,480			18,504		65
66 PHYSICAL THERAPY	0.582602						66
69 ELECTROCARDIOLOGY	0.067269	849,018			57,113		69
70 ELECTROENCEPHALOGRAPHY							70
70.50 SLEEP LAB	0.132856	143,484			19,063		70.50
71 MEDICAL SUPPLIES CHRGD TO PATI	0.464447	735,766			341,724		71
72 IMPL. DEV. CHARGED TO PATIENT	0.443059	205,093			90,868		72
73 DRUGS CHARGED TO PATIENTS	0.150975	563,558			85,083		73
76 INDUSTRIAL MEDICINE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.454340	785,444			1,142,303		90
91 EMERGENCY	0.243693	478,330		11	116,566	3	91
92 OBSERVATION BEDS	0.275606	234,169			64,538		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		9,907,532		11	3,246,330	3	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		9,907,532		11	3,246,330	3	202

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED 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	466,995		466,995	14,038	33.27	7,885	262,334	30
31 INTENSIVE CARE UNIT	57,775		57,775	1,982	29.15	465	13,555	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)	524,770		524,770	16,020		8,350	275,889	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0151) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

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	146,852	4,927,406	0.029803	564,091	16,812	50
51 RECOVERY ROOM	10,403	1,699,960	0.006120	122,188	748	51
53 ANESTHESIOLOGY	5,643	4,433,521	0.001273	502,329	639	53
54 RADIOLOGY-DIAGNOSTIC	85,228	7,407,309	0.011506	853,932	9,825	54
56 RADIOISOTOPE						56
60 LABORATORY	62,024	12,165,559	0.005098	2,730,790	13,922	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	20,450	3,065,669	0.006671	936,723	6,249	65
66 PHYSICAL THERAPY	37,057	594,789	0.062303	120,000	7,476	66
69 ELECTROCARDIOLOGY	15,601	3,103,752	0.005026	573,380	2,882	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	2,376	193,360	0.012288			70.50
71 MEDICAL SUPPLIES CHRGD TO PA	41,293	3,262,293	0.012658	481,547	6,095	71
72 IMPL. DEV. CHARGED TO PATIENT	6,383	594,566	0.010736	145,000	1,557	72
73 DRUGS CHARGED TO PATIENTS	19,162	11,863,017	0.001615	4,884,176	7,888	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	94,009	1,076,614	0.087319			90
91 EMERGENCY	25,304	3,819,904	0.006624	246,964	1,636	91
92 OBSERVATION BEDS	10,180	463,897	0.021945			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	581,965	58,671,616		12,161,120	75,729	200

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
APPLICABLE [] TITLE XVIII-PT A
BOXES [XX] 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
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
40 OTHER SPECIAL CARE (SPECIFY)					40
41 SUBPROVIDER - IPF					41
42 SUBPROVIDER - IRF					42
43 SUBPROVIDER I					43
44 NURSERY					44
45 SKILLED NURSING FACILITY					45
200 NURSING FACILITY					200
TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	14,038		7,885	30
31 INTENSIVE CARE UNIT	1,982		465	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)	16,020		8,350	200

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
 PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-0151)	[]	SUB (OTHER)	[]	ICF/MR	[XX]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER
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				
51	RECOVERY ROOM					51				
53	ANESTHESIOLOGY					53				
54	RADIOLOGY-DIAGNOSTIC					54				
56	RADIOISOTOPE					56				
60	LABORATORY					60				
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30				
65	RESPIRATORY THERAPY					65				
66	PHYSICAL THERAPY					66				
69	ELECTROCARDIOLOGY					69				
70	ELECTROENCEPHALOGRAPHY					70				
70.50	SLEEP LAB					70.50				
71	MEDICAL SUPPLIES CHRGED TO PA					71				
72	IMPL. DEV. CHARGED TO PATIENT					72				
73	DRUGS CHARGED TO PATIENTS					73				
76	INDUSTRIAL MEDICINE					76				
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				
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 (14-0151)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER		
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	4,927,406			564,091		50
51	RECOVERY ROOM	1,699,960			122,188		51
53	ANESTHESIOLOGY	4,433,521			502,329		53
54	RADIOLOGY-DIAGNOSTIC	7,407,309			853,932		54
56	RADIOISOTOPE						56
60	LABORATORY	12,165,559			2,730,790		60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	3,065,669			936,723		65
66	PHYSICAL THERAPY	594,789			120,000		66
69	ELECTROCARDIOLOGY	3,103,752			573,380		69
70	ELECTROENCEPHALOGRAPHY						70
70.50	SLEEP LAB	193,360					70.50
71	MEDICAL SUPPLIES CHRGED TO P	3,262,293			481,547		71
72	IMPL. DEV. CHARGED TO PATIEN	594,566			145,000		72
73	DRUGS CHARGED TO PATIENTS	11,863,017			4,884,176		73
76	INDUSTRIAL MEDICINE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	1,076,614					90
91	EMERGENCY	3,819,904			246,964		91
92	OBSERVATION BEDS	463,897					92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	58,671,616			12,161,120		200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0151) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	CHARGE RATIO FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.395623						50
51 RECOVERY ROOM	0.130451						51
53 ANESTHESIOLOGY	0.035009						53
54 RADIOLOGY-DIAGNOSTIC	0.251936						54
56 RADIOISOTOPE							56
60 LABORATORY	0.177007						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.258866						65
66 PHYSICAL THERAPY	0.582602						66
69 ELECTROCARDIOLOGY	0.067269						69
70 ELECTROENCEPHALOGRAPHY							70
70.50 SLEEP LAB	0.132856						70.50
71 MEDICAL SUPPLIES CHRGD TO PATI	0.464447						71
72 IMPL. DEV. CHARGED TO PATIENT	0.443059						72
73 DRUGS CHARGED TO PATIENTS	0.150975						73
76 INDUSTRIAL MEDICINE							76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	1.454340						90
91 EMERGENCY	0.243693						91
92 OBSERVATION BEDS	0.275606						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0151) [] 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)	14,038	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	14,038	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,732	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)	5,188	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)	5,865,364	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	5,865,364	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	15,440,145	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,440,145	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.379878	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)	1,124.39	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)	5,865,364	37

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0151) [] 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) 417.82 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,167,650 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) 2,167,650 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	1,578,640	1,982	796.49	1,098	874,546	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)					3,414,047	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,456,243	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 204,612 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 118,239 51
 52 TOTAL PROGRAM EXCLUDABLE COST 322,851 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 6,133,392 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 306 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 417.82 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 127,853 89

	COST 1	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						
90 CAPITAL-RELATED COST	466,995	5,865,364	0.079619	127,853	10,180	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0151) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] 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)	14,038	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	14,038	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	13,732	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)	7,885	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)	5,865,364	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	5,865,364	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	15,440,145	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	15,440,145	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	0.379878	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)	1,124.39	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)	5,865,364	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0151) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] 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) 417.82 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 3,294,511 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 3,294,511 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	1,578,640	1,982	796.49	465	370,368	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)					2,391,635	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					6,056,514	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 275,889 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 75,729 51
 52 TOTAL PROGRAM EXCLUDABLE COST 351,618 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 5,704,896 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 306 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	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) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST						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 (14-0151) [] 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		7,017,464		30
31 INTENSIVE CARE UNIT		1,770,717		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.395623	878,868	347,700	50
51 RECOVERY ROOM	0.130451	226,736	29,578	51
53 ANESTHESIOLOGY	0.035009	795,074	27,835	53
54 RADIOLOGY-DIAGNOSTIC	0.251936	1,528,068	384,975	54
56 RADIOISOTOPE				56
60 LABORATORY	0.177007	3,282,076	580,950	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.258866	1,686,851	436,668	65
66 PHYSICAL THERAPY	0.582602	211,813	123,403	66
69 ELECTROCARDIOLOGY	0.067269	975,472	65,619	69
70 ELECTROENCEPHALOGRAPHY				70
70.50 SLEEP LAB	0.132856			70.50
71 MEDICAL SUPPLIES CHRGD TO PATI	0.464447	954,349	443,245	71
72 IMPL. DEV. CHARGED TO PATIENT	0.443059	214,227	94,915	72
73 DRUGS CHARGED TO PATIENTS	0.150975	5,179,170	781,925	73
76 INDUSTRIAL MEDICINE				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	1.454340	6,877	10,001	90
91 EMERGENCY	0.243693	337,355	82,211	91
92 OBSERVATION BEDS	0.275606	18,223	5,022	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		16,295,159	3,414,047	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		16,295,159		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-0151) SUB (OTHER) S/B SNF PPS
 APPLICABLE 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		10,272,950		30
31 INTENSIVE CARE UNIT		657,000		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.395623	564,091	223,167	50
51 RECOVERY ROOM	0.130451	122,188	15,940	51
53 ANESTHESIOLOGY	0.035009	502,329	17,586	53
54 RADIOLOGY-DIAGNOSTIC	0.251936	853,932	215,136	54
56 RADIOISOTOPE				56
60 LABORATORY	0.177007	2,730,790	483,369	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.258866	936,723	242,486	65
66 PHYSICAL THERAPY	0.582602	120,000	69,912	66
69 ELECTROCARDIOLOGY	0.067269	573,380	38,571	69
70 ELECTROENCEPHALOGRAPHY				70
70.50 SLEEP LAB	0.132856			70.50
71 MEDICAL SUPPLIES CHRGD TO PATI	0.464447	481,547	223,653	71
72 IMPL. DEV. CHARGED TO PATIENT	0.443059	145,000	64,244	72
73 DRUGS CHARGED TO PATIENTS	0.150975	4,884,176	737,388	73
76 INDUSTRIAL MEDICINE				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	1.454340			90
91 EMERGENCY	0.243693	246,964	60,183	91
92 OBSERVATION BEDS	0.275606			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		12,161,120	2,391,635	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		12,161,120		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0151)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,422,411	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	22,495	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	16,182	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	118.16	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)	4.00	5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		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)	4.00	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	4.89	11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	4.89	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	5.00	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	5.26	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	5.05	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	5.05	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.042739	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.042226	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.042226	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	169,622	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)	-4.00	24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	169,622	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.2493	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.5429	31
32	SUM OF LINES 30 AND 31	0.7922	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.5457	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	4,050,410	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)	11,664,938	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)	11,664,938	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	729,475	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0151)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	108,704	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)	12,503,117	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	12,503,117	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	753,538	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	122,323	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	783,069	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	548,148	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	545,323	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	12,175,404	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SEQUESTRATION PER PSR)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	12,175,404	71
72	INTERIM PAYMENTS	11,701,409	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	473,995	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0151) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		11,653,399		2,008,976
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.		369		NONE
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 02/03/2012	47,641	02/03/2012	32,660
	.02			3.01
	.03			3.02
	.04			3.03
	.05			3.04
	.06			3.05
	.07			3.06
	.08			3.07
	.09			3.08
	.50	NONE		3.09
	.51			3.50
	.52			3.51
	.53			3.52
	.54			3.53
	.55			3.54
	.56			3.55
	.57			3.56
	.58			3.57
	.59			3.58
	.99			3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		47,641		32,660
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		11,701,409		2,041,636

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
	.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			6.01
	TO .02			6.02
	PROVIDER .03			
	PROVIDER .04			
	TO .05			
	PROGRAM .06			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)				7

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

PROVIDER CCN: 14-0151 SACRED HEART HOSPITAL
PERIOD FROM 07/01/2011 TO 06/30/2012

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

VERSION: 2011.10
11/20/2012 10:36

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0151) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,290	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	6,286	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	9	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	15,714	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	79,341,072	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	19,404	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)	1,053,120	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1,148,065	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	-94,945	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0151) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

	INPATIENT	OUTPATIENT
	TITLE V OR	TITLE V OR
	TITLE XIX	TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES		1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)		4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)		7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8 ROUTINE SERVICE CHARGES	8,719,995	8
9 ANCILLARY SERVICE CHARGES	12,161,120	9
10 ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11 INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12 TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	20,881,115	12
CUSTOMARY CHARGES		
13 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15 RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000	1.000000 15
16 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	20,881,115	16
17 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	20,881,115	17
18 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19 INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20 COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21 COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)		21
PROSPECTIVE PAYMENT AMOUNT		
22 OTHER THAN OUTLIER PAYMENTS		22
23 OUTLIER PAYMENTS		23
24 PROGRAM CAPITAL PAYMENTS		24
25 CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26 ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27 SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28 CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29 SUM OF LINES 27 AND 21		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30 EXCESS OF REASONABLE COST (FROM LINE 18)		30
31 SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)		31
32 DEDUCTIBLES		32
33 COINSURANCE		33
34 ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35 UTILIZATION REVIEW		35
36 SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)		36
37 OTHER ADJUSTMENTS (TO ZERO OUT SETTLEMENT, SINCE NO ADD)		37
38 SUBTOTAL (LINE 36 ± LINE 37)		38
39 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40 TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)		40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII
 BOX: [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		3.90	10
11	TOTAL WEIGHTED FTE COUNT		3.90	11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)		4.50	12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)		5.00	13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)		4.47	14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT		4.47	17
18	PER RESIDENT AMOUNT		91,247.89	18
19	APPROVED AMOUNT FOR RESIDENT COSTS		407,878	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			407,878 25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
26	INPATIENT DAYS	PART A 6,286	CARE 9	26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	15,714	15,714	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.400025	0.000573	28
29	PROGRAM DIRECT GME AMOUNT	163,161	234	29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		33	30
31	NET PROGRAM DIRECT GME AMOUNT			163,362 31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			6,456,243 37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			6,456,243 41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			3,246,333 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			3,246,333 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			9,702,576 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.665415 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.334585 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			163,362 48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			108,704 49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			54,658 50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII
 BOX: [XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996		1	
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)		2	
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA		3	
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		3.01	
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))		4	
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.01	
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)		4.02	
5	FTE ADJUSTED CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)		5	
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)		6	
7	ENTER THE LESSER OF LINE 5 OR LINE 6		7	
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE UNWEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD				
		INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	8,350	181	26
27	TOTAL INPATIENT DAYS (SEE INSTRUCTIONS)	15,714	15,714	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.531373	0.011518	28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			30
31	NET PROGRAM DIRECT GME AMOUNT			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,380,370			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4,384,249			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	610,540			7
8	PREPAID EXPENSES	131,414			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS	-1,160,092			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	7,346,481			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	4,415,857			15
16	ACCUMULATED DEPRECIATION				16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT				19
20	ACCUMULATED DEPRECIATION				20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	4,415,857			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	9,629,656			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	9,629,656			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	21,391,994			36
LIABILITIES AND FUND BALANCES		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,015,383			37
38	SALARIES, WAGES & FEES PAYABLE	954,493			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	81,058			43
44	OTHER CURRENT LIABILITIES	1,722,933			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,773,867			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	9,722			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	9,722			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	3,783,589			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	17,608,405			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)	17,608,405			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	21,391,994			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		8,195,484							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		9,412,921							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		17,608,405							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		17,608,405							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									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)		17,608,405							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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	17,709,956		17,709,956	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				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)	17,709,956		17,709,956	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	2,959,500		2,959,500	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	2,959,500		2,959,500	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	20,669,456		20,669,456	18
19 ANCILLARY SERVICES	30,370,857		30,370,857	19
20 OUTPATIENT SERVICES		28,300,758	28,300,758	20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER PATIENT REVENUES		1,873,049	1,873,049	28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	51,040,313	30,173,807	81,214,120	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		26,444,759	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35 VARIANCE BETWEEN COST REPORT AND F/S			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)		26,444,759	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	81,214,120	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	45,727,178	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	35,486,942	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	26,444,759	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	9,042,183	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	597	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	29,485	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	13,543	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	14,083	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,234	21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (MISCELLANEOUS INCOME)	5,669	24
24.01	OTHER (GRANT INCOME)	42,829	24.01
24.02	OTHER (GAIN ON SALE OF ASSETS)	5,603	24.02
24.03	OTHER (ER PROF FEES)	51,388	24.03
24.04	OTHER (ANEST PROF FEES)	317,627	24.04
24.05	OTHER (EEG PROF FEES)	3,008	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	485,066	25
26	TOTAL (LINE 5 PLUS LINE 25)	9,527,249	26
27	OTHER EXPENSES (INCOME TAX EXPENSE)	114,328	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	114,328	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	9,412,921	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-015) [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	603,879	1
2 CAPITAL DRG OUTLIER PAYMENTS	110	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	42.93	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	5.05	4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0338	5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	20,411	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.2493	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.5429	8
9 SUM OF LINES 7 AND 8	0.7922	9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1740	10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	105,075	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	729,475	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

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-015) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (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)	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9 SUM OF LINES 7 AND 8	9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1 PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2 PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3 NET PROGRAM INPATIENT CAPITAL COSTS 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	SUBTOTAL	I&R COST &	TOTAL
	NARY CAP- REL COSTS	(COLS.0-4) 2A		POST STEP- DOWN ADJS	
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5.10					5.10
5.20					5.20
5.30					5.30
5.40					5.40
5.50					5.50
6					6
7					7
8					8
9					9
10					10
11					11
13					13
14					14
15					15
16					16
17					17
19					19
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30					30
31					31
ANCILLARY SERVICE COST CENTERS					
50					50
51					51
53					53
54					54
56					56
60					60
62.30					62.30
65					65
66					66
69					69
70					70
70.50					70.50
71					71
72					72
73					73
76					76
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
90					90
91					91
92					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113					113
118					118
NONREIMBURSABLE COST CENTERS					
192					192
194					194
200					200
201					201
202					202
TOTAL (SUM OF LINE 118 AND LINES 190-201)					
203					203
204					204
204					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	36.96		56.17				93.13 30
31 INTENSIVE CARE UNIT	55.40		23.46				78.86 31
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	17.84	29.86	11.45				59.15 50
51 RECOVERY ROOM	13.34	34.77	7.19				55.30 51
53 ANESTHESIOLOGY	17.93	29.68	11.33				58.94 53
54 RADIOLOGY-DIAGNOSTIC	20.63	30.51	11.53				62.67 54
60 LABORATORY	26.98	1.67	22.45				51.10 60
65 RESPIRATORY THERAPY	55.02	2.33	30.56				87.91 65
66 PHYSICAL THERAPY	35.61		20.18				55.79 66
69 ELECTROCARDIOLOGY	31.43	27.35	18.47				77.25 69
70.50 SLEEP LAB		74.21					74.21 70.50
71 MEDICAL SUPPLIES CHRGED TO PATI	29.25	22.55	14.76				66.56 71
72 IMPL. DEV. CHARGED TO PATIENT	36.03	34.49	24.39				94.91 72
73 DRUGS CHARGED TO PATIENTS	43.66	4.75	41.17				89.58 73
90 CLINIC	0.64	72.96					73.60 90
91 EMERGENCY	8.83	12.52	6.47				27.82 91
92 OBSERVATION BEDS	3.93	50.48					54.41 92
200 TOTAL CHARGES	27.77	16.89	20.73				65.39 200

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	326,927	1.42	-326,927	-3.25		1
2	CAP REL COSTS-MVBLE EQUIP	798,574	3.47	-798,574	-7.95		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	1,490,024	6.48	-1,490,024	-14.83		4
5.10	NONPATIENT TELEPHONES	188,072	0.82	-188,072	-1.87		5.10
5.20	DATA PROCESSING	322,427	1.40	-322,427	-3.21		5.20
5.30	PURCHASING	172,476	0.75	-172,476	-1.72		5.30
5.40	CASHIERING	719,010	3.13	-719,010	-7.15		5.40
5.50	ADMINISTRATIVE & GENERAL	2,390,614	10.40	-2,390,614	-23.79		5.50
6	MAINTENANCE & REPAIRS	375,323	1.63	-375,323	-3.73		6
7	OPERATION OF PLANT	859,069	3.74	-859,069	-8.55		7
8	LAUNDRY & LINEN SERVICE	133,001	0.58	-133,001	-1.32		8
9	HOUSEKEEPING	345,644	1.50	-345,644	-3.44		9
10	DIETARY	491,243	2.14	-491,243	-4.89		10
11	CAFETERIA	230,054	1.00	-230,054	-2.29		11
13	NURSING ADMINISTRATION	300,626	1.31	-300,626	-2.99		13
14	CENTRAL SERVICES & SUPPLY	290,109	1.26	-290,109	-2.89		14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	295,732	1.29	-295,732	-2.94		16
17	SOCIAL SERVICE	50,667	0.22	-50,667	-0.50		17
19	NONPHYSICIAN ANESTHETISTS						19
21	I&R SRVCES-SALARY & FRINGES APP	270,088	1.17	-270,088	-2.69		21
22	I&R SRVCES-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,518,639	10.96	3,389,708	33.73	5,908,347	25.70
31	INTENSIVE CARE UNIT	964,824	4.20	613,816	6.11	1,578,640	6.87
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	964,956	4.20	1,282,865	12.77	2,247,821	9.78
51	RECOVERY ROOM	126,926	0.55	94,835	0.94	221,761	0.96
53	ANESTHESIOLOGY	59,228	0.26	111,776	1.11	171,004	0.74
54	RADIOLOGY-DIAGNOSTIC	1,176,595	5.12	700,451	6.97	1,877,046	8.17
56	RADIOISOTOPE						56
60	LABORATORY	1,465,998	6.38	692,651	6.89	2,158,649	9.39
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	524,616	2.28	268,981	2.68	793,597	3.45
66	PHYSICAL THERAPY	163,701	0.71	182,824	1.82	346,525	1.51
69	ELECTROCARDIOLOGY	84,356	0.37	124,429	1.24	208,785	0.91
70	ELECTROENCEPHALOGRAPHY						70
70.50	SLEEP LAB	14,647	0.06	11,042	0.11	25,689	0.11
71	MEDICAL SUPPLIES CHRGD TO PATI	920,657	4.01	594,504	5.92	1,515,161	6.59
72	IMPL. DEV. CHARGED TO PATIENT	169,876	0.74	93,552	0.93	263,428	1.15
73	DRUGS CHARGED TO PATIENTS	1,344,962	5.85	446,052	4.44	1,791,014	7.79
76	INDUSTRIAL MEDICINE						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
90	CLINIC	785,574	3.42	780,189	7.76	1,565,763	6.81
91	EMERGENCY	551,106	2.40	390,653	3.89	941,759	4.10
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	1,000,921	4.35	203,515	2.03	1,204,436	5.24
194	OTHER NONREIMBURSABLE	100,271	0.44	67,837	0.68	168,108	0.73
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	22,987,533	100.00			22,987,533	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	146,852	4,927,406	0.029803	878,868	26,193	50
51 RECOVERY ROOM	10,403	1,699,960	0.006120	226,736	1,388	51
53 ANESTHESIOLOGY	5,643	4,433,521	0.001273	795,074	1,012	53
54 RADIOLOGY-DIAGNOSTIC	85,228	7,407,309	0.011506	1,528,068	17,582	54
56 RADIOISOTOPE						56
60 LABORATORY	62,024	12,165,559	0.005098	3,282,076	16,732	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	20,450	3,065,669	0.006671	1,686,851	11,253	65
66 PHYSICAL THERAPY	37,057	594,789	0.062303	211,813	13,197	66
69 ELECTROCARDIOLOGY	15,601	3,103,752	0.005026	975,472	4,903	69
70 ELECTROENCEPHALOGRAPHY						70
70.50 SLEEP LAB	2,376	193,360	0.012288			70.50
71 MEDICAL SUPPLIES CHRGD TO PATI	41,293	3,262,293	0.012658	954,349	12,080	71
72 IMPL. DEV. CHARGED TO PATIENT	6,383	594,566	0.010736	214,227	2,300	72
73 DRUGS CHARGED TO PATIENTS	19,162	11,863,017	0.001615	5,179,170	8,364	73
76 INDUSTRIAL MEDICINE						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	94,009	1,076,614	0.087319	6,877	600	90
91 EMERGENCY	25,304	3,819,904	0.006624	337,355	2,235	91
92 OBSERVATION BEDS	10,180	463,897	0.021945	18,223	400	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	581,965	58,671,616		16,295,159	118,239	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	466,995		466,995	14,038	33.27	5,188	172,605 30
31	INTENSIVE CARE UNIT	57,775		57,775	1,982	29.15	1,098	32,007 31
200	TOTAL	524,770		524,770	16,020		6,286	204,612 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS								204,612
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS								118,239
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS								322,851
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)								1,282
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)								6,286
PER DISCHARGE CAPITAL COSTS								251.83
PER DIEM CAPITAL COSTS								51.36

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)	6,133,392
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	25,083,340
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.245

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)	322,851
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.013

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)	3,246,330
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)	9,907,532
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.328