

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: 08-27-2012 TIME: 07:42____
 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 JACKSON PARK HOSPITAL (14-0177) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2011 AND ENDING 03/31/2012, 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 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						1
2 SUBPROVIDER - IPF		-159,447	60,401			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		-159,447	60,401			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: 7531 SOUTH STONEY ISLAND AVENUE
 2 CITY: CHICAGO STATE: IL

P.O.BOX:
 ZIP CODE: 60649 COUNTY: COOK

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL JACKSON PARK HOSPITAL	14-0177	16974	1	07/01/1966	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: 04/01/2011			TO: 03/31/2012				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.								2	N 23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	17,718	2,238		28			24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL. 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 PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N		N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	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)	Y			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, 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))
ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
65	FAMILY MEDICINE	1350	1.81	14.37	0.111867
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))

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
67 FAMILY MEDICINE	1350	1.18	16.01	0.068645
INPATIENT PSYCHIATRIC FACILITY PPS				
70 IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 70
71 IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				71
INPATIENT REHABILITATION FACILITY PPS				
75 IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 75
76 IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.				76
LONG TERM CARE HOSPITAL PPS				
80 IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.				N 80
TEFRA PROVIDERS				
85 IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.				N 85
86 DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				N 86
TITLE V AND XIX INPATIENT SERVICES				
90 DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.				N 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 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)?				N 2 105
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 N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.			118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

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

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

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII PART A	TITLE XVIII PART B	TITLE V	TITLE 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	161

MULTICAMPUS

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), 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 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

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 R	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 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.			Y 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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 Y	2 08/08/2012	3 Y	4 08/08/2012
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)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R 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	
	1	2	
36	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	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.	N	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: JENNY	LAST NAME: DABROWSKI	TITLE: CONSULTANT	41
42	EMPLOYER: STRATEGIC REIMBURSEMENT, INC			42
43	PHONE NUMBER: 630-530-7100 EX 104	E-MAIL ADDRESS: JENNY.DABROWSKI@SRINC.ORG		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	33,453,260	33,453,260	1,510,068.52	22.15	1	
2	NON-PHYSICIAN ANESTHETIST PART A						2	
3	NON-PHYSICIAN ANESTHETIST PART B						3	
4	PHYSICIAN-PART A						4	
4.01	PHYSICIAN-PART A - TEACHING						4.01	
5	PHYSICIAN-PART B		2,991,294	2,991,294	63,137.00	47.38	5	
6	NON-PHYSICIAN-PART B						6	
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21	834,489	834,489	36,408.00	22.92	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)		269,741	269,741	18,180.00	14.84	10	
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (SEE INSTRUCTIONS)		7,024,207	7,024,207	103,938.00	67.58	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 WAGE-RELATED COSTS						16	
17	WAGE-RELATED COSTS (CORE)		8,482,123	8,482,123			17	
18	WAGE-RELATED COSTS (OTHER)						18	
19	EXCLUDED AREAS		70,728	70,728			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		355,210	355,210			23	
24	WAGE-RELATED COSTS (RHC/FQHC)						24	
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM) OVERHEAD COSTS - DIRECT SALARIES		218,808	218,808			25	
26	EMPLOYEE BENEFITS		309,841	309,841	16,214.00	19.11	26	
27	ADMINISTRATIVE & GENERAL		6,017,813	6,017,813	219,541.00	27.41	27	
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)		994,252	994,252	4,464.00	222.73	28	
29	MAINTENANCE & REPAIRS		464,128	464,128	21,974.00	21.12	29	
30	OPERATION OF PLANT		1,121,963	1,121,963	75,434.00	14.87	30	
31	LAUNDRY & LINEN SERVICE						31	
32	HOUSEKEEPING		909,145	909,145	77,298.60	11.76	32	
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33	
34	DIETARY		948,338	-280,523	667,815	51,447.00	12.98	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35	
36	CAFETERIA			280,523	280,523	21,611.00	12.98	36
37	MAINTENANCE OF PERSONNEL						37	
38	NURSING ADMINISTRATION		2,053,208	2,053,208	122,185.75	16.80	38	
39	CENTRAL SERVICES AND SUPPLY		136,097	136,097	12,242.00	11.12	39	
40	PHARMACY		847,364	847,364	29,628.00	28.60	40	
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		880,469	880,469	55,617.97	15.83	41	
42	SOCIAL SERVICE		220,579	220,579	10,794.00	20.44	42	
43	OTHER GENERAL SERVICE						43	

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	30,621,729		30,621,729	1,414,987.5	21.64	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	269,741		269,741	18,180.00	14.84	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	30,351,988		30,351,988	1,396,807.5	21.73	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	7,024,207		7,024,207	103,938.00	67.58	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	8,482,123		8,482,123		27.95%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	45,858,318		45,858,318	1,500,745.5	30.56	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	14,903,197		14,903,197	718,451.32	20.74	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST		3
4 PRIOR YEAR PENSION SERVICE COST	160,534	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	6,010,988	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	313,313	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	-90,108	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	2,640,773	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE	91,369	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION		21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT		23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	9,126,869	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/27/2012 07:42

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		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.239146	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				24,750,290	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				103,539,247	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				24,760,997	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				10,707	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				10,707	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	6,965,476	4,374	6,969,850		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,665,766	1,046	1,666,812		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	4,379	4,374	8,753		22
23	COST OF CHARITY CARE	1,661,387	-3,328	1,658,059		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					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			34,045,916		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			887,640		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			33,158,276		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			7,929,669		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			9,587,728		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			9,598,435		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100				2,447,715	1
2	00200					2
3	00300					3
4	00400	309,841	108,587	418,428	9,126,869	4
5	00500	6,017,813	23,918,515	29,936,328	-11,382,640	5
6	00600	464,128	829,830	1,293,958		6
7	00700	1,121,963	1,555,636	2,677,599	-160,545	7
8	00800		437,557	437,557		8
9	00900	909,145	832,052	1,741,197	-31,399	9
10	01000	948,338	494,947	1,443,285	-426,931	10
11	01100				426,931	11
12	01200		4,064	4,064		12
13	01300	2,053,208	1,306,793	3,360,001		13
14	01400	136,097	215,015	351,112	-63,028	14
15	01500	847,364	1,463,465	2,310,829	-1,394,350	15
16	01600	880,469	157,312	1,037,781		16
17	01700	220,579	225,816	446,395		17
19	01900					19
20	02000					20
21	02100	834,489	82,736	917,225		21
22	02200		147,310	147,310		22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	8,191,072	4,524,352	12,715,424	-382,389	30
31	03100	1,348,797	683,997	2,032,794		31
43	04300	412,189	559,071	971,260		43
ANCILLARY SERVICE COST CENTERS						
50	05000	725,080	1,192,443	1,917,523	-573,481	50
52	05200	37,134	18,113	55,247	382,389	52
54	05400	1,000,126	1,082,608	2,082,734		54
56	05600	104,602	71,702	176,304		56
57	05700	349,984	222,017	572,001		57
60	06000		4,039,884	4,039,884		60
62.30	06250					62.30
65	06500	1,162,706	333,914	1,496,620		65
66	06600	208,936	454,108	663,044		66
71	07100				471,465	71
72	07200				165,044	72
73	07300				1,394,350	73
74	07400		402,739	402,739		74
76	03550	227,058	539,054	766,112		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	1,103,928	5,109,495	6,213,423		91
92	09200					92
93	05340	3,511,615	1,655,641	5,167,256		93
93.01	04950	56,858	103	56,961		93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		33,183,519	52,668,876	85,852,395		118
NONREIMBURSABLE COST CENTERS						
192	19200		107,963	107,963		192
194	07950	269,741	56,797	326,538		194
200		33,453,260	52,833,636	86,286,896		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	2,447,715	-11,385	2,436,330	1
2	00200	CAP REL COSTS-MVBLE EQUIP				2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	9,545,297	-795	9,544,502	4
5	00500	ADMINISTRATIVE & GENERAL	18,553,688	-346,274	18,207,414	5
6	00600	MAINTENANCE & REPAIRS	1,293,958		1,293,958	6
7	00700	OPERATION OF PLANT	2,517,054	-505,716	2,011,338	7
8	00800	LAUNDRY & LINEN SERVICE	437,557		437,557	8
9	00900	HOUSEKEEPING	1,709,798		1,709,798	9
10	01000	DIETARY	1,016,354		1,016,354	10
11	01100	CAFETERIA	426,931	-220,437	206,494	11
12	01200	MAINTENANCE OF PERSONNEL	4,064	-191	3,873	12
13	01300	NURSING ADMINISTRATION	3,360,001		3,360,001	13
14	01400	CENTRAL SERVICES & SUPPLY	288,084		288,084	14
15	01500	PHARMACY	916,479		916,479	15
16	01600	MEDICAL RECORDS & LIBRARY	1,037,781	-8,481	1,029,300	16
17	01700	SOCIAL SERVICE	446,395		446,395	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD	917,225	-25,000	892,225	21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD	147,310		147,310	22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	12,333,035	-461,972	11,871,063	30
31	03100	INTENSIVE CARE UNIT	2,032,794	-25,000	2,007,794	31
43	04300	NURSERY	971,260	-526,187	445,073	43
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	1,344,042	-275,594	1,068,448	50
52	05200	DELIVERY ROOM & LABOR ROOM	437,636		437,636	52
54	05400	RADIOLOGY-DIAGNOSTIC	2,082,734	-900,000	1,182,734	54
56	05600	RADIOISOTOPE	176,304		176,304	56
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	572,001		572,001	57
60	06000	LABORATORY	4,039,884		4,039,884	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	1,496,620	-75,000	1,421,620	65
66	06600	PHYSICAL THERAPY	663,044	-22,000	641,044	66
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	471,465		471,465	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	165,044		165,044	72
73	07300	DRUGS CHARGED TO PATIENTS	1,394,350		1,394,350	73
74	07400	RENAL DIALYSIS	402,739		402,739	74
76	03550	OP PSYCH	766,112		766,112	76
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
91	09100	EMERGENCY	6,213,423	-1,705,978	4,507,445	91
92	09200	OBSERVATION BEDS				92
93	05340	FAMILY PRACTICE	5,167,256	-2,872,746	2,294,510	93
93.01	04950	CANCER CENTER	56,961		56,961	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	85,852,395	-7,982,756	77,869,639	118
NONREIMBURSABLE COST CENTERS						
192	19200	PHYSICIANS' PRIVATE OFFICES	107,963		107,963	192
194	07950	OTHER NON REIMBURSEABLE COST CENTER	326,538		326,538	194
200		TOTAL (SUM OF LINES 118-199)	86,286,896	-7,982,756	78,304,140	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 DEPRECIATION EXPENSE	A	CAP REL COSTS-BLDG & FIXT	1		2,009,023 1
500 TOTAL RECLASSIFICATIONS					2,009,023 500
CODE LETTER - A					
1 FRINGE BENEFITS	B	EMPLOYEE BENEFITS	4		9,126,869 1
2					2
3					3
500 TOTAL RECLASSIFICATIONS					9,126,869 500
CODE LETTER - B					
1 INTEREST	C	CAP REL COSTS-BLDG & FIXT	1		316,879 1
500 TOTAL RECLASSIFICATIONS					316,879 500
CODE LETTER - C					
1 CAFETERIA	D	CAFETERIA	11	280,523	146,408 1
500 TOTAL RECLASSIFICATIONS				280,523	146,408 500
CODE LETTER - D					
1 CENTRAL SUPPLY	E	MEDICAL SUPPLIES CHRGED TO PA	71		471,465 1
2					2
500 TOTAL RECLASSIFICATIONS					471,465 500
CODE LETTER - E					
1 CHARGEABLE DRUGS	F	DRUGS CHARGED TO PATIENTS	73		1,394,350 1
500 TOTAL RECLASSIFICATIONS					1,394,350 500
CODE LETTER - F					
1 LABOR ROOM	G	DELIVERY ROOM & LABOR ROOM	52	307,372	75,017 1
500 TOTAL RECLASSIFICATIONS				307,372	75,017 500
CODE LETTER - G					
1 PROPERTY INSURANCE	H	CAP REL COSTS-BLDG & FIXT	1		121,813 1
500 TOTAL RECLASSIFICATIONS					121,813 500
CODE LETTER - H					
1 IMPLANTS	I	IMPL. DEV. CHARGED TO PATIENT	72		165,044 1
500 TOTAL RECLASSIFICATIONS					165,044 500
CODE LETTER - I					
GRAND TOTAL (INCREASES)				587,895	13,826,868

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7	
			LINE #	SALARY	OTHER	REF.	
	1	6	7	8	9	10	
1 DEPRECIATION EXPENSE	A	ADMINISTRATIVE & GENERAL	5		2,009,023		9 1
500 TOTAL RECLASSIFICATIONS					2,009,023		500
CODE LETTER - A							
1 FRINGE BENEFITS	B	ADMINISTRATIVE & GENERAL	5		8,934,925		1
2 OPERATION OF PLANT			7		160,545		2
3 HOUSEKEEPING			9		31,399		3
500 TOTAL RECLASSIFICATIONS					9,126,869		500
CODE LETTER - B							
1 INTEREST	C	ADMINISTRATIVE & GENERAL	5		316,879		11 1
500 TOTAL RECLASSIFICATIONS					316,879		500
CODE LETTER - C							
1 CAFETERIA	D	DIETARY	10	280,523	146,408		1
500 TOTAL RECLASSIFICATIONS				280,523	146,408		500
CODE LETTER - D							
1 CENTRAL SUPPLY	E	CENTRAL SERVICES & SUPPLY	14		63,028		1
2 OPERATING ROOM			50		408,437		2
500 TOTAL RECLASSIFICATIONS					471,465		500
CODE LETTER - E							
1 CHARGEABLE DRUGS	F	PHARMACY	15		1,394,350		1
500 TOTAL RECLASSIFICATIONS					1,394,350		500
CODE LETTER - F							
1 LABOR ROOM	G	ADULTS & PEDIATRICS	30	307,372	75,017		1
500 TOTAL RECLASSIFICATIONS				307,372	75,017		500
CODE LETTER - G							
1 PROPERTY INSURANCE	H	ADMINISTRATIVE & GENERAL	5		121,813		9 1
500 TOTAL RECLASSIFICATIONS					121,813		500
CODE LETTER - H							
1 IMPLANTS	I	OPERATING ROOM	50		165,044		1
500 TOTAL RECLASSIFICATIONS					165,044		500
CODE LETTER - I							
GRAND TOTAL (DECREASES)					587,895	13,826,868	

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	2,482,024					2,482,024	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	41,682,666	881,483		881,483		42,564,149	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	23,563,154					23,563,154	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	67,727,844	881,483		881,483		68,609,327	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	67,727,844	881,483		881,483		68,609,327	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 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
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL (SUM OF LINES 1-2)							3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS OF GROSS ASSETS FOR RATIO (SEE INSTR.)

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION 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	2,130,836		305,494				2,436,330
2 CAP REL COSTS-MVBLE EQUIP							2
3 TOTAL	2,130,836		305,494				2,436,330

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-5,545	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2 3
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					4
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					5
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					6
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					7
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-84,570	ADMINISTRATIVE & GENERAL	5	8
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-10,543	ADMINISTRATIVE & GENERAL	5	9
9 PARKING LOT (CHAPTER 21)					10
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-7,011,026			11
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					12
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				13
13 LAUNDRY AND LINEN SERVICE					14
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-220,437	CAFETERIA	11	15
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS	B	-98,932	OPERATION OF PLANT	7	16
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					17
17 SALE OF DRUGS TO OTHER THAN PATIENTS					18
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-8,481	MEDICAL RECORDS & LIBRARY	16	19
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					20
20 VENDING MACHINES	B	-1,417	ADMINISTRATIVE & GENERAL	5	21
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					22
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					23
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				25
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	26
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	27
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	28
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	29
29 PHYSICIANS' ASSISTANT					30
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				32
32 CAH HIT ADJ FOR DEPRECIATION AND RENTAL OF QUARTERS	B	-191	MAINTENANCE OF PERSONNEL	12	33
33 MISC INCOME	B	-142,043	ADMINISTRATIVE & GENERAL	5	34
34					35
35					36
36					36.03
36.03 LOCKER & ID REVENUE	B	-795	EMPLOYEE BENEFITS	4	36.05
36.05 CLERICAL FEES	B	-319	ADMINISTRATIVE & GENERAL	5	36.06
36.06 DIALYSIS RENT	B	-213,083	OPERATION OF PLANT	7	9 36.07
36.07 CAPITALIZED INTEREST	B	-5,840	CAP REL COSTS-BLDG & FIXT	1	11 36.20
36.20 DOCTOR'S OFFICE RENTALS	B	-155,686	OPERATION OF PLANT	7	9 37
37					38
38 FUND RAISING	A	14,167	ADMINISTRATIVE & GENERAL	5	39
39 CANCER CENTER RENT	B	-38,015	OPERATION OF PLANT	7	40
40					41
41					42
42					43
43					44
44					45
45					46
46					47
47					48
48					49
49					50
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-7,982,756			

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						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2		3	4	5	6	7	8	9
1	21	I&R SRVCES-SALARY & FRIN	25,000	25,000					1
3	30	ADULTS & PEDIATRICS	461,972	461,972					3
4	31	INTENSIVE CARE UNIT	25,000	25,000					4
5	43	NURSERY	526,187	526,187					5
7	50	OPERATING ROOM	275,594	275,594					7
8	54	RADIOLOGY-DIAGNOSTIC	900,000	900,000					8
10	65	RESPIRATORY THERAPY	75,000	75,000					10
11	66	PHYSICAL THERAPY	22,000	22,000					11
12	91	EMERGENCY	1,705,978	1,705,978					12
14	5	ADMINISTRATIVE & GENERAL	121,549	2,080					14
15	93	FAMILY PRACTICE	2,872,746	2,872,746					15
200		TOTAL	7,011,026	6,891,557					200

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	21 I&R SRVCES-SALARY & FRIN	AGGREGATE						25,000	1
3	30 ADULTS & PEDIATRICS	AGGREGATE						461,972	3
4	31 INTENSIVE CARE UNIT	AGGREGATE						25,000	4
5	43 NURSERY							526,187	5
7	50 OPERATING ROOM	AGGREGATE						275,594	7
8	54 RADIOLOGY-DIAGNOSTIC	AGGREGATE						900,000	8
10	65 RESPIRATORY THERAPY	AGGREGATE						75,000	10
11	66 PHYSICAL THERAPY	AGGREGATE						22,000	11
12	91 EMERGENCY	AGGREGATE						1,705,978	12
14	5 ADMINISTRATIVE & GENERAL	AGGREGATE						121,549	14
15	93 FAMILY PRACTICE	AGGREGATE						2,872,746	15
200	TOTAL							7,011,026	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	2,436,330	2,436,330				1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	9,544,502	10,864	9,555,366			4
5 ADMINISTRATIVE & GENERAL	18,207,414	134,599	1,734,960	20,076,973	20,076,973	5
6 MAINTENANCE & REPAIRS	1,293,958	26,027	133,810	1,453,795	501,274	6
7 OPERATION OF PLANT	2,011,338	579,721	323,466	2,914,525	1,004,940	7
8 LAUNDRY & LINEN SERVICE	437,557	9,516		447,073	154,153	8
9 HOUSEKEEPING	1,709,798	31,205	262,110	2,003,113	690,681	9
10 DIETARY	1,016,354	35,392	192,534	1,244,280	429,033	10
11 CAFETERIA	206,494	24,742	80,876	312,112	107,617	11
12 MAINTENANCE OF PERSONNEL	3,873	29,025		32,898	11,343	12
13 NURSING ADMINISTRATION	3,360,001	15,234	591,948	3,967,183	1,367,901	13
14 CENTRAL SERVICES & SUPPLY	288,084	35,321	39,237	362,642	125,040	14
15 PHARMACY	916,479	14,496	244,298	1,175,273	405,239	15
16 MEDICAL RECORDS & LIBRARY	1,029,300	35,821	253,843	1,318,964	454,784	16
17 SOCIAL SERVICE	446,395	11,840	63,594	521,829	179,929	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD	892,225		240,587	1,132,812	390,598	21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	147,310	5,527		152,837	52,699	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	11,871,063	579,428	2,272,888	14,723,379	5,076,694	30
31 INTENSIVE CARE UNIT	2,007,794	25,297	388,864	2,421,955	835,100	31
43 NURSERY	445,073	9,231	118,836	573,140	197,621	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,068,448	106,066	209,043	1,383,557	477,056	50
52 DELIVERY ROOM & LABOR ROOM	437,636	11,071	99,322	548,029	188,963	52
54 RADIOLOGY-DIAGNOSTIC	1,182,734	78,065	288,340	1,549,139	534,149	54
56 RADIOISOTOPE	176,304	13,220	30,157	219,681	75,747	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	572,001	5,575	100,902	678,478	233,942	57
60 LABORATORY	4,039,884	29,112		4,068,996	1,403,006	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,421,620	22,776	335,213	1,779,609	613,616	65
66 PHYSICAL THERAPY	641,044	30,611	60,237	731,892	252,359	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	471,465			471,465	162,563	71
72 IMPL. DEV. CHARGED TO PATIENT	165,044			165,044	56,908	72
73 DRUGS CHARGED TO PATIENTS	1,394,350			1,394,350	480,777	73
74 RENAL DIALYSIS	402,739	76,479		479,218	165,236	74
76 OP PSYCH	766,112	17,216	65,462	848,790	292,666	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	4,507,445	47,811	318,267	4,873,523	1,680,410	91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE	2,294,510	182,299	1,012,413	3,489,222	1,203,098	93
93.01 CANCER CENTER	56,961	26,344	16,392	99,697	34,376	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	77,869,639	2,259,931	9,477,599	77,615,473	19,839,518	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	107,963	176,399		284,362	98,049	192
194 OTHER NON REIMBURSEABLE COST CENTER	326,538		77,767	404,305	139,406	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	78,304,140	2,436,330	9,555,366	78,304,140	20,076,973	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 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	1,955,069					6
7 OPERATION OF PLANT	500,431	4,419,896				7
8 LAUNDRY & LINEN SERVICE	8,215	24,960	634,401			8
9 HOUSEKEEPING	26,937	81,848		2,802,579		9
10 DIETARY	30,552	92,831		60,320	1,857,016	10
11 CAFETERIA	21,358	64,896		42,169		11
12 MAINTENANCE OF PERSONNEL	25,055	76,128		49,467		12
13 NURSING ADMINISTRATION	13,150	39,957		25,963		13
14 CENTRAL SERVICES & SUPPLY	30,490	92,644		60,198		14
15 PHARMACY	12,514	38,023		24,706		15
16 MEDICAL RECORDS & LIBRARY	30,921	93,954		61,050		16
17 SOCIAL SERVICE	10,220	31,055		20,179		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	4,771	14,498		9,420		22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	500,177	1,519,781	586,067	987,533	1,741,495	30
31 INTENSIVE CARE UNIT	21,837	66,352	38,877	43,115	115,521	31
43 NURSERY	7,968	24,211	9,457	15,732		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	91,559	278,201		180,771		50
52 DELIVERY ROOM & LABOR ROOM	9,556	29,037		18,868		52
54 RADIOLOGY-DIAGNOSTIC	67,388	204,756		133,047		54
56 RADIOISOTOPE	11,412	34,674		22,530		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	4,812	14,622		9,501		57
60 LABORATORY	25,130	76,357		49,616		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	19,660	59,738		38,817		65
66 PHYSICAL THERAPY	26,424	80,288		52,170		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS	66,019	200,596		130,344		74
76 OP PSYCH	14,862	45,157		29,342		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	41,272	125,404		81,485		91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE	157,366	478,153		310,696		93
93.01 CANCER CENTER	22,741	69,098		44,899		93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,802,797	3,957,219	634,401	2,501,938	1,857,016	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	152,272	462,677		300,641		192
194 OTHER NON REIMBURSEABLE COST CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,955,069	4,419,896	634,401	2,802,579	1,857,016	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	548,152					11
12 MAINTENANCE OF PERSONNEL		194,891				12
13 NURSING ADMINISTRATION	66,406	36,772	5,517,332			13
14 CENTRAL SERVICES & SUPPLY	6,659		132,804	810,477		14
15 PHARMACY	16,099				1,671,854	15
16 MEDICAL RECORDS & LIBRARY	30,230					16
17 SOCIAL SERVICE	5,867					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	19,784					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	184,046	121,347	3,670,705	159,590		30
31 INTENSIVE CARE UNIT	29,111		580,594	80,923		31
43 NURSERY	7,269	36,772	144,979	13,257		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,901		337,083	308,161		50
52 DELIVERY ROOM & LABOR ROOM	384		7,666	1,925		52
54 RADIOLOGY-DIAGNOSTIC	18,959			6,165		54
56 RADIOISOTOPE	1,187			1,403		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	6,252			87,613		57
60 LABORATORY				731		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	23,142			84,578		65
66 PHYSICAL THERAPY	4,251			96		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				17,320		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					1,671,854	73
74 RENAL DIALYSIS				401		74
76 OP PSYCH	4,319			767		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	32,265		643,501	38,131		91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE	73,540			9,368		93
93.01 CANCER CENTER	1,481			48		93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	548,152	194,891	5,517,332	810,477	1,671,854	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON REIMBURSEABLE COST CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	548,152	194,891	5,517,332	810,477	1,671,854	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	I&R SALARY & FRINGES 21	I&R PROGRAM COSTS 22	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	1,989,903					16
17 SOCIAL SERVICE		769,079				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD			1,523,410			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				254,009		22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,838,297	710,485	867,172	144,589	32,831,357	30
31 INTENSIVE CARE UNIT	121,943	47,130	36,620	6,106	4,445,184	31
43 NURSERY	29,663	11,464	37,597	6,269	1,115,399	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			74,217	12,375	3,159,881	50
52 DELIVERY ROOM & LABOR ROOM					804,428	52
54 RADIOLOGY-DIAGNOSTIC			11,719	1,954	2,527,276	54
56 RADIOISOTOPE					366,634	56
57 COMPUTED TOMOGRAPHY (CT) SCAN					1,035,220	57
60 LABORATORY					5,623,836	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			52,245	8,711	2,680,116	65
66 PHYSICAL THERAPY					1,147,480	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					651,348	71
72 IMPL. DEV. CHARGED TO PATIENT					221,952	72
73 DRUGS CHARGED TO PATIENTS					3,546,981	73
74 RENAL DIALYSIS					1,041,814	74
76 OP PSYCH					1,235,903	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY			37,597	6,269	7,559,857	91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE			406,243	67,736	6,195,422	93
93.01 CANCER CENTER					272,340	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,989,903	769,079	1,523,410	254,009	76,462,428	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES					1,298,001	192
194 OTHER NON REIMBURSEABLE COST CENTER					543,711	194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,989,903	769,079	1,523,410	254,009	78,304,140	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS		TOTAL	
	25	26		
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	-1,011,761		31,819,596	30
31 INTENSIVE CARE UNIT	-42,726		4,402,458	31
43 NURSERY	-43,866		1,071,533	43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	-86,592		3,073,289	50
52 DELIVERY ROOM & LABOR ROOM			804,428	52
54 RADIOLOGY-DIAGNOSTIC	-13,673		2,513,603	54
56 RADIOISOTOPE			366,634	56
57 COMPUTED TOMOGRAPHY (CT) SCAN			1,035,220	57
60 LABORATORY			5,623,836	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	-60,956		2,619,160	65
66 PHYSICAL THERAPY			1,147,480	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			651,348	71
72 IMPL. DEV. CHARGED TO PATIENT			221,952	72
73 DRUGS CHARGED TO PATIENTS			3,546,981	73
74 RENAL DIALYSIS			1,041,814	74
76 OP PSYCH			1,235,903	76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	-43,866		7,515,991	91
92 OBSERVATION BEDS				92
93 FAMILY PRACTICE	-473,979		5,721,443	93
93.01 CANCER CENTER			272,340	93.01
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	-1,777,419		74,685,009	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES			1,298,001	192
194 OTHER NON REIMBURSEABLE COST CENTER			543,711	194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	-1,777,419		76,526,721	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	SUBTOTAL	EMPLOYEE	ADMINIS-	
	CAP-REL COSTS	BLDGS & FIXTURES		BENEFITS	TRATIVE & GENERAL	
	0	1	2A	4	5	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5	233	10,864	11,097	11,097		4
5	192,726	134,599	327,325	2,016	329,341	5
6	1,029	26,027	27,056	155	8,223	6
7		579,721	579,721	376	16,485	7
8		9,516	9,516		2,529	8
9	23,226	31,205	54,431	305	11,330	9
10		35,392	35,392	224	7,038	10
11		24,742	24,742	94	1,765	11
12		29,025	29,025		186	12
13	376	15,234	15,610	688	22,438	13
14		35,321	35,321	46	2,051	14
15	54	14,496	14,550	284	6,647	15
16	46,903	35,821	82,724	295	7,460	16
17		11,840	11,840	74	2,951	17
19						19
20						20
21				280	6,407	21
22		5,527	5,527		864	22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	14,448	579,428	593,876	2,634	83,284	30
31	5,115	25,297	30,412	452	13,699	31
43	2,217	9,231	11,448	138	3,242	43
ANCILLARY SERVICE COST CENTERS						
50	12,515	106,066	118,581	243	7,825	50
52		11,071	11,071	115	3,100	52
54		78,065	78,065	335	8,762	54
56		13,220	13,220	35	1,243	56
57		5,575	5,575	117	3,837	57
60		29,112	29,112		23,014	60
62.30						62.30
65	28,095	22,776	50,871	390	10,065	65
66		30,611	30,611	70	4,140	66
71	127,319		127,319		2,667	71
72					933	72
73					7,886	73
74		76,479	76,479		2,710	74
76		17,216	17,216	76	4,801	76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
91	45,087	47,811	92,898	370	27,565	91
92						92
93		182,299	182,299	1,176	19,735	93
93.01		26,344	26,344	19	564	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	499,343	2,259,931	2,759,274	11,007	325,446	118
NONREIMBURSABLE COST CENTERS						
192		176,399	176,399		1,608	192
194	6,351		6,351	90	2,287	194
200						200
201						201
202	505,694	2,436,330	2,942,024	11,097	329,341	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						5
6	35,434					6
7	9,073	605,655				7
8	149	3,420	15,614			8
9	488	11,216		77,770		9
10	554	12,721		1,674	57,603	10
11	387	8,893		1,170		11
12	454	10,432		1,373		12
13	238	5,475		720		13
14	553	12,695		1,670		14
15	227	5,210		686		15
16	560	12,874		1,694		16
17	185	4,255		560		17
19						19
20						20
21						21
22	86	1,987		261		22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	9,065	208,253	14,424	27,403	54,020	30
31	396	9,092	957	1,196	3,583	31
43	144	3,318	233	437		43
ANCILLARY SERVICE COST CENTERS						
50	1,659	38,122		5,016		50
52	173	3,979		524		52
54	1,221	28,058		3,692		54
56	207	4,751		625		56
57	87	2,004		264		57
60	455	10,463		1,377		60
62.30						62.30
65	356	8,186		1,077		65
66	479	11,002		1,448		66
71						71
72						72
73						73
74	1,197	27,488		3,617		74
76	269	6,188		814		76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
91	748	17,184		2,261		91
92						92
93	2,852	65,521		8,622		93
93.01	412	9,468		1,246		93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	32,674	542,255	15,614	69,427	57,603	118
NONREIMBURSABLE COST CENTERS						
192	2,760	63,400		8,343		192
194						194
200						200
201						201
202	35,434	605,655	15,614	77,770	57,603	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	MAIN- TENANCE OF PERSONNEL 12	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	37,051					11
12 MAINTENANCE OF PERSONNEL		41,470				12
13 NURSING ADMINISTRATION	4,489	7,825	57,483			13
14 CENTRAL SERVICES & SUPPLY	450		1,384	54,170		14
15 PHARMACY	1,088				28,692	15
16 MEDICAL RECORDS & LIBRARY	2,043					16
17 SOCIAL SERVICE	397					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	1,337					22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	12,441	25,820	38,244	10,667		30
31 INTENSIVE CARE UNIT	1,968		6,049	5,409		31
43 NURSERY	491	7,825	1,510	886		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,142		3,512	20,595		50
52 DELIVERY ROOM & LABOR ROOM	26		80	129		52
54 RADIOLOGY-DIAGNOSTIC	1,281			412		54
56 RADIOISOTOPE	80			94		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	423			5,856		57
60 LABORATORY				49		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	1,564			5,653		65
66 PHYSICAL THERAPY	287			6		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				1,158		71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS					28,692	73
74 RENAL DIALYSIS				27		74
76 OP PSYCH	292			51		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	2,181		6,704	2,549		91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE	4,971			626		93
93.01 CANCER CENTER	100			3		93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	37,051	41,470	57,483	54,170	28,692	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON REIMBURSEABLE COST CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	37,051	41,470	57,483	54,170	28,692	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	I&R PROGRAM COSTS	SUBTOTAL	
	16	17	21	22	24	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY	107,650					16
17 SOCIAL SERVICE		20,262				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD			6,687			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				10,062		22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	99,448	18,718			1,198,297	30
31 INTENSIVE CARE UNIT	6,597	1,242			81,052	31
43 NURSERY	1,605	302			31,579	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM					196,695	50
52 DELIVERY ROOM & LABOR ROOM					19,197	52
54 RADIOLOGY-DIAGNOSTIC					121,826	54
56 RADIOISOTOPE					20,255	56
57 COMPUTED TOMOGRAPHY (CT) SCAN					18,163	57
60 LABORATORY					64,470	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					78,162	65
66 PHYSICAL THERAPY					48,043	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					131,144	71
72 IMPL. DEV. CHARGED TO PATIENT					933	72
73 DRUGS CHARGED TO PATIENTS					36,578	73
74 RENAL DIALYSIS					111,518	74
76 OP PSYCH					29,707	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY					152,460	91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE					285,802	93
93.01 CANCER CENTER					38,156	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	107,650	20,262			2,664,037	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES					252,510	192
194 OTHER NON REIMBURSEABLE COST CENTER					8,728	194
200 CROSS FOOT ADJUSTMENTS			6,687	10,062	16,749	200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	107,650	20,262	6,687	10,062	2,942,024	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	25	26	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY			15
16 MEDICAL RECORDS & LIBRARY			16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		1,198,297	30
31 INTENSIVE CARE UNIT		81,052	31
43 NURSERY		31,579	43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM		196,695	50
52 DELIVERY ROOM & LABOR ROOM		19,197	52
54 RADIOLOGY-DIAGNOSTIC		121,826	54
56 RADIOISOTOPE		20,255	56
57 COMPUTED TOMOGRAPHY (CT) SCAN		18,163	57
60 LABORATORY		64,470	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY		78,162	65
66 PHYSICAL THERAPY		48,043	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		131,144	71
72 IMPL. DEV. CHARGED TO PATIENT		933	72
73 DRUGS CHARGED TO PATIENTS		36,578	73
74 RENAL DIALYSIS		111,518	74
76 OP PSYCH		29,707	76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
91 EMERGENCY		152,460	91
92 OBSERVATION BEDS			92
93 FAMILY PRACTICE		285,802	93
93.01 CANCER CENTER		38,156	93.01
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)		2,664,037	118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES		252,510	192
194 OTHER NON REIMBURSEABLE COST CENTER		8,728	194
200 CROSS FOOT ADJUSTMENTS		16,749	200
201 NEGATIVE COST CENTER			201
202 TOTAL (SUM OF LINES 118-201)		2,942,024	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	
	1	4	5A	5	6	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	307,222					1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS	1,370	33,143,419				4
5 ADMINISTRATIVE & GENERAL	16,973	6,017,813	-20,076,973	58,227,167		5
6 MAINTENANCE & REPAIRS	3,282	464,128		1,453,795	285,597	6
7 OPERATION OF PLANT	73,103	1,121,963		2,914,525	73,103	7
8 LAUNDRY & LINEN SERVICE	1,200			447,073	1,200	8
9 HOUSEKEEPING	3,935	909,145		2,003,113	3,935	9
10 DIETARY	4,463	667,815		1,244,280	4,463	10
11 CAFETERIA	3,120	280,523		312,112	3,120	11
12 MAINTENANCE OF PERSONNEL	3,660			32,898	3,660	12
13 NURSING ADMINISTRATION	1,921	2,053,208		3,967,183	1,921	13
14 CENTRAL SERVICES & SUPPLY	4,454	136,097		362,642	4,454	14
15 PHARMACY	1,828	847,364		1,175,273	1,828	15
16 MEDICAL RECORDS & LIBRARY	4,517	880,469		1,318,964	4,517	16
17 SOCIAL SERVICE	1,493	220,579		521,829	1,493	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD		834,489		1,132,812		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD	697			152,837	697	22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	73,066	7,883,700		14,723,379	73,066	30
31 INTENSIVE CARE UNIT	3,190	1,348,797		2,421,955	3,190	31
43 NURSERY	1,164	412,189		573,140	1,164	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	13,375	725,080		1,383,557	13,375	50
52 DELIVERY ROOM & LABOR ROOM	1,396	344,506		548,029	1,396	52
54 RADIOLOGY-DIAGNOSTIC	9,844	1,000,126		1,549,139	9,844	54
56 RADIOISOTOPE	1,667	104,602		219,681	1,667	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	703	349,984		678,478	703	57
60 LABORATORY	3,671			4,068,996	3,671	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	2,872	1,162,706		1,779,609	2,872	65
66 PHYSICAL THERAPY	3,860	208,936		731,892	3,860	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				471,465		71
72 IMPL. DEV. CHARGED TO PATIENT				165,044		72
73 DRUGS CHARGED TO PATIENTS				1,394,350		73
74 RENAL DIALYSIS	9,644			479,218	9,644	74
76 OP PSYCH	2,171	227,058		848,790	2,171	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	6,029	1,103,928		4,873,523	6,029	91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE	22,988	3,511,615		3,489,222	22,988	93
93.01 CANCER CENTER	3,322	56,858		99,697	3,322	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	284,978	32,873,678	-20,076,973	57,538,500	263,353	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	22,244			284,362	22,244	192
194 OTHER NON REIMBURSEABLE COST CENTER		269,741		404,305		194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	2,436,330	9,555,366		20,076,973	1,955,069	202
203 UNIT COST MULT-WS B PT I	7.930194	0.288304		0.344804	6.845552	203
204 COST TO BE ALLOC PER B PT II		11,097		329,341	35,434	204
205 UNIT COST MULT-WS B PT II		0.000335		0.005656	0.124070	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET 7	PATIENT DAYS 8	SQUARE FEET 9	MEALS SERVED 10	FTE'S SERVED 11	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5						5
6						6
7	212,494					7
8	1,200	41,726				8
9	3,935		207,359			9
10	4,463		4,463	123,312		10
11	3,120		3,120		48,487	11
12	3,660		3,660			12
13	1,921		1,921		5,874	13
14	4,454		4,454		589	14
15	1,828		1,828		1,424	15
16	4,517		4,517		2,674	16
17	1,493		1,493		519	17
19						19
20						20
21						21
22	697		697		1,750	22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30	73,066	38,547	73,066	115,641	16,280	30
31	3,190	2,557	3,190	7,671	2,575	31
43	1,164	622	1,164		643	43
ANCILLARY SERVICE COST CENTERS						
50	13,375		13,375		1,495	50
52	1,396		1,396		34	52
54	9,844		9,844		1,677	54
56	1,667		1,667		105	56
57	703		703		553	57
60	3,671		3,671			60
62.30						62.30
65	2,872		2,872		2,047	65
66	3,860		3,860		376	66
71						71
72						72
73						73
74	9,644		9,644			74
76	2,171		2,171		382	76
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
91	6,029		6,029		2,854	91
92						92
93	22,988		22,988		6,505	93
93.01	3,322		3,322		131	93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118	190,250	41,726	185,115	123,312	48,487	118
NONREIMBURSABLE COST CENTERS						
192	22,244		22,244			192
194						194
200						200
201						201
202	4,419,896	634,401	2,802,579	1,857,016	548,152	202
203	20,800,098	15,203,974	13,515,589	15,059,491	11,305,133	203
204	605,655	15,614	77,770	57,603	37,051	204
205	2,850,222	0,374,203	0,375,050	0,467,132	0,764,143	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY PATIENT DAYS	
	12	13	14	15	16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL	53					12
13 NURSING ADMINISTRATION	10	24,470				13
14 CENTRAL SERVICES & SUPPLY		589	698,589			14
15 PHARMACY				10,000		15
16 MEDICAL RECORDS & LIBRARY					41,726	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	33	16,280	137,558		38,547	30
31 INTENSIVE CARE UNIT		2,575	69,751		2,557	31
43 NURSERY	10	643	11,427		622	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,495	265,619			50
52 DELIVERY ROOM & LABOR ROOM		34	1,659			52
54 RADIOLOGY-DIAGNOSTIC			5,314			54
56 RADIOISOTOPE			1,209			56
57 COMPUTED TOMOGRAPHY (CT) SCAN			75,518			57
60 LABORATORY			630			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			72,902			65
66 PHYSICAL THERAPY			83			66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			14,929			71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS				10,000		73
74 RENAL DIALYSIS			346			74
76 OP PSYCH			661			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY		2,854	32,867			91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE			8,075			93
93.01 CANCER CENTER			41			93.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	53	24,470	698,589	10,000	41,726	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
194 OTHER NON REIMBURSEABLE COST CENTER						194
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	194,891	5,517,332	810,477	1,671,854	1,989,903	202
203 UNIT COST MULT-WS B PT I	3,677.188679	225.473314	1.160163	167.185400	47.689762	203
204 COST TO BE ALLOC PER B PT II	41,470	57,483	54,170	28,692	107,650	204
205 UNIT COST MULT-WS B PT II	782.452830	2.349121	0.077542	2.869200	2.579926	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	SOCIAL SERVICE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
	PATIENT DAYS	21	22	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5 ADMINISTRATIVE & GENERAL				5
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE	41,726			17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD		6,240		21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			6,240	22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	38,547	3,552	3,552	30
31 INTENSIVE CARE UNIT	2,557	150	150	31
43 NURSERY	622	154	154	43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM		304	304	50
52 DELIVERY ROOM & LABOR ROOM				52
54 RADIOLOGY-DIAGNOSTIC		48	48	54
56 RADIOISOTOPE				56
57 COMPUTED TOMOGRAPHY (CT) SCAN				57
60 LABORATORY				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY		214	214	65
66 PHYSICAL THERAPY				66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				71
72 IMPL. DEV. CHARGED TO PATIENT				72
73 DRUGS CHARGED TO PATIENTS				73
74 RENAL DIALYSIS				74
76 OP PSYCH				76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY		154	154	91
92 OBSERVATION BEDS				92
93 FAMILY PRACTICE		1,664	1,664	93
93.01 CANCER CENTER				93.01
OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	41,726	6,240	6,240	118
NONREIMBURSABLE COST CENTERS				
192 PHYSICIANS' PRIVATE OFFICES				192
194 OTHER NON REIMBURSEABLE COST CENTER				194
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	769,079	1,523,410	254,009	202
203 UNIT COST MULT-WS B PT I	18.431649	244.136218	40.706571	203
204 COST TO BE ALLOC PER B PT II	20,262	6,687	10,062	204
205 UNIT COST MULT-WS B PT II	0.485597	1.071635	1.612500	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL COSTS	RCE	TOTAL COSTS	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT		DISALLOWANCE		
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	31,819,596		31,819,596		31,819,596	30
31 INTENSIVE CARE UNIT	4,402,458		4,402,458		4,402,458	31
43 NURSERY	1,071,533		1,071,533		1,071,533	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,073,289		3,073,289		3,073,289	50
52 DELIVERY ROOM & LABOR ROOM	804,428		804,428		804,428	52
54 RADIOLOGY-DIAGNOSTIC	2,513,603		2,513,603		2,513,603	54
56 RADIOISOTOPE	366,634		366,634		366,634	56
57 COMPUTED TOMOGRAPHY (CT) SC	1,035,220		1,035,220		1,035,220	57
60 LABORATORY	5,623,836		5,623,836		5,623,836	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	2,619,160		2,619,160		2,619,160	65
66 PHYSICAL THERAPY	1,147,480		1,147,480		1,147,480	66
71 MEDICAL SUPPLIES CHRGD TO	651,348		651,348		651,348	71
72 IMPL. DEV. CHARGED TO PATIE	221,952		221,952		221,952	72
73 DRUGS CHARGED TO PATIENTS	3,546,981		3,546,981		3,546,981	73
74 RENAL DIALYSIS	1,041,814		1,041,814		1,041,814	74
76 OP PSYCH	1,235,903		1,235,903		1,235,903	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	7,515,991		7,515,991		7,515,991	91
92 OBSERVATION BEDS	1,743,101		1,743,101		1,743,101	92
93 FAMILY PRACTICE	5,721,443		5,721,443		5,721,443	93
93.01 CANCER CENTER	272,340		272,340		272,340	93.01
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	76,428,110		76,428,110		76,428,110	200
201 LESS OBSERVATION BEDS	1,743,101		1,743,101		1,743,101	201
202 TOTAL (SEE INSTRUCTIONS)	74,685,009		74,685,009		74,685,009	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	74,513,961		74,513,961			30
31 INTENSIVE CARE UNIT	8,995,324		8,995,324			31
43 NURSERY	636,058		636,058			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,875,314	4,281,140	9,156,454	0.335642	0.335642	0.335642 50
52 DELIVERY ROOM & LABOR ROOM	425,738	520,814	946,552	0.849851	0.849851	0.849851 52
54 RADIOLOGY-DIAGNOSTIC	8,018,013	6,656,701	14,674,714	0.171288	0.171288	0.171288 54
56 RADIOISOTOPE	1,032,897	494,733	1,527,630	0.240002	0.240002	0.240002 56
57 COMPUTED TOMOGRAPHY (CT) SC	11,862,012	12,727,686	24,589,698	0.042100	0.042100	0.042100 57
60 LABORATORY	38,740,734	35,214,054	73,954,788	0.076044	0.076044	0.076044 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	17,302,978	3,304,951	20,607,929	0.127095	0.127095	0.127095 65
66 PHYSICAL THERAPY	1,124,915	1,846,910	2,971,825	0.386120	0.386120	0.386120 66
71 MEDICAL SUPPLIES CHRGD TO	912,734	670,216	1,582,950	0.411477	0.411477	0.411477 71
72 IMPL. DEV. CHARGED TO PATIE	341,098	60,747	401,845	0.552332	0.552332	0.552332 72
73 DRUGS CHARGED TO PATIENTS	24,296,428	3,152,073	27,448,501	0.129223	0.129223	0.129223 73
74 RENAL DIALYSIS	2,129,663	124,740	2,254,403	0.462124	0.462124	0.462124 74
76 OP PSYCH		3,303,263	3,303,263	0.374146	0.374146	0.374146 76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	9,977,190	8,298,925	18,276,115	0.411247	0.411247	0.411247 91
92 OBSERVATION BEDS	1,401,707	7,365,393	8,767,100	0.198823	0.198823	0.198823 92
93 FAMILY PRACTICE		17,496,562	17,496,562	0.327004	0.327004	0.327004 93
93.01 CANCER CENTER		192,872	192,872	1.412025	1.412025	1.412025 93.01
OTHER REIMBURSABLE COST CENTERS						
200 SUBTOTAL (SEE INSTRUCTIONS)	206,586,764	105,711,780	312,298,544			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	206,586,764	105,711,780	312,298,544			202

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
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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.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	5	6	7	
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,198,297		1,198,297	29.38	12,000	352,560	30
31 INTENSIVE CARE UNIT	81,052		81,052	31.70	1,287	40,798	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	31,579		31,579	50.77			43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,310,928		1,310,928		13,287	393,358	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0177) [] SUB (OTHER)
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF
 BOXES [] TITLE XIX [] IRF

[XX] PPS
 [] TEFRA

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
	(FROM WKST B, PT. II, COL. 26)	(FROM WKST C, PT. I, COL. 8)	(COL.1 ÷ COL.2)			
	1	2	3	4	5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	196,695	9,156,454	0.021482	2,221,535	47,723	50
52 DELIVERY ROOM & LABOR ROOM	19,197	946,552	0.020281	4,420	90	52
54 RADIOLOGY-DIAGNOSTIC	121,826	14,674,714	0.008302	2,606,508	21,639	54
56 RADIOISOTOPE	20,255	1,527,630	0.013259	529,235	7,017	56
57 COMPUTED TOMOGRAPHY (CT) SCAN	18,163	24,589,698	0.000739	5,104,463	3,772	57
60 LABORATORY	64,470	73,954,788	0.000872	20,168,308	17,587	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	78,162	20,607,929	0.003793	7,576,422	28,737	65
66 PHYSICAL THERAPY	48,043	2,971,825	0.016166	598,089	9,669	66
71 MEDICAL SUPPLIES CHRGD TO PA	131,144	1,582,950	0.082848	401,937	33,300	71
72 IMPL. DEV. CHARGED TO PATIENT	933	401,845	0.002322	285,192	662	72
73 DRUGS CHARGED TO PATIENTS	36,578	27,448,501	0.001333	9,159,740	12,210	73
74 RENAL DIALYSIS	111,518	2,254,403	0.049467	1,034,880	51,192	74
76 OP PSYCH	29,707	3,303,263	0.008993			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY	152,460	18,276,115	0.008342	2,852,489	23,795	91
92 OBSERVATION BEDS	65,643	8,767,100	0.007487	654,222	4,898	92
93 FAMILY PRACTICE	285,802	17,496,562	0.016335			93
93.01 CANCER CENTER	38,156	192,872	0.197831			93.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	1,418,752	228,153,201		53,197,440	262,291	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
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					45
TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
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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 PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	40,781		12,000		30
31 INTENSIVE CARE UNIT	2,557		1,287		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	622				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	43,960		13,287		200

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0177) [] 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 COST 1			SCHOOL 2	MEDICAL EDUCATION COST 4	COST (SUM OF COLS. 1-4) 5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
54 RADIOLOGY-DIAGNOSTIC						54
56 RADIOISOTOPE						56
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76 OP PSYCH						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
91 EMERGENCY						91
92 OBSERVATION BEDS						92
93 FAMILY PRACTICE						93
93.01 CANCER CENTER						93.01
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 (14-0177) [] 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 CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 ÷ COL. 7)	(COL. 6 ÷ COL. 7)	PGM CHARGES	(COL. 8 x COL. 10)	(COL. 9 x COL. 12)	(COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	9,156,454			2,221,535		981,793	50
52 DELIVERY ROOM & LABOR ROOM	946,552			4,420		198	52
54 RADIOLOGY-DIAGNOSTIC	14,674,714			2,606,508		884,350	54
56 RADIOISOTOPE	1,527,630			529,235		160,654	56
57 COMPUTED TOMOGRAPHY (CT) SCA	24,589,698			5,104,463		1,713,730	57
60 LABORATORY	73,954,788			20,168,308		114,994	60
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
65 RESPIRATORY THERAPY	20,607,929			7,576,422		854,982	65
66 PHYSICAL THERAPY	2,971,825			598,089		118,248	66
71 MEDICAL SUPPLIES CHRGED TO P	1,582,950			401,937		59,771	71
72 IMPL. DEV. CHARGED TO PATIEN	401,845			285,192		53,399	72
73 DRUGS CHARGED TO PATIENTS	27,448,501			9,159,740		385,693	73
74 RENAL DIALYSIS	2,254,403			1,034,880		64,680	74
76 OP PSYCH	3,303,263					456,597	76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
91 EMERGENCY	18,276,115			2,852,489		1,184,109	91
92 OBSERVATION BEDS	8,767,100			654,222		1,074,777	92
93 FAMILY PRACTICE	17,496,562						93
93.01 CANCER CENTER	192,872						93.01
OTHER REIMBURSABLE COST CENTERS							
200 TOTAL (SUM OF LINES 50-199)	228,153,201			53,197,440		8,107,975	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0177) [] 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		COST REIMB.	COST REIMB.	COST	COST		
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT		
FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO		
PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS		
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.335642	981,793			329,531			50
52 DELIVERY ROOM & LABOR ROOM	0.849851	198			168			52
54 RADIOLOGY-DIAGNOSTIC	0.171288	884,350			151,479			54
56 RADIOISOTOPE	0.240002	160,654			38,557			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.042100	1,713,730			72,148			57
60 LABORATORY	0.076044	114,994			8,745			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.127095	854,982			108,664			65
66 PHYSICAL THERAPY	0.386120	118,248			45,658			66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.411477	59,771			24,594			71
72 IMPL. DEV. CHARGED TO PATIENT	0.552332	53,399			29,494			72
73 DRUGS CHARGED TO PATIENTS	0.129223	385,693			49,840			73
74 RENAL DIALYSIS	0.462124	64,680			29,890			74
76 OP PSYCH	0.374146	456,597			170,834			76
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
91 EMERGENCY	0.411247	1,184,109			486,961			91
92 OBSERVATION BEDS	0.198823	1,074,777			213,690			92
93 FAMILY PRACTICE	0.327004							93
93.01 CANCER CENTER	1.412025							93.01
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		8,107,975			1,760,253			200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		8,107,975			1,760,253			202

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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.1 MINUS COL.2)	(COL.3 + COL.4)	PGM DAYS	(COL.5 x COL.6)	
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS	1,198,297		1,198,297	40,781	29.38	16,767	492,614 30
31 INTENSIVE CARE UNIT	81,052		81,052	2,557	31.70	604	19,147 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	31,579		31,579	622	50.77	347	17,617 43
44 SKILLED NURSING FACILITY							44
45 NURSING FACILITY							45
200 TOTAL (LINES 30-199)	1,310,928		1,310,928	43,960		17,718	529,378 200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0177) [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII-PT A [] IPF
 BOXES [XX] TITLE XIX [] IRF

[XX] PPS
 [] TEFRA
 [] OTHER

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL
	COST	CHARGES	COST TO		
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)
	COL. 26)	COL. 8)	COL.2)		
	1	2	3	4	5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	196,695	9,156,454	0.021482		50
52 DELIVERY ROOM & LABOR ROOM	19,197	946,552	0.020281		52
54 RADIOLOGY-DIAGNOSTIC	121,826	14,674,714	0.008302		54
56 RADIOISOTOPE	20,255	1,527,630	0.013259		56
57 COMPUTED TOMOGRAPHY (CT) SCAN	18,163	24,589,698	0.000739		57
60 LABORATORY	64,470	73,954,788	0.000872		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
65 RESPIRATORY THERAPY	78,162	20,607,929	0.003793		65
66 PHYSICAL THERAPY	48,043	2,971,825	0.016166		66
71 MEDICAL SUPPLIES CHRGD TO PA	131,144	1,582,950	0.082848		71
72 IMPL. DEV. CHARGED TO PATIENT	933	401,845	0.002322		72
73 DRUGS CHARGED TO PATIENTS	36,578	27,448,501	0.001333		73
74 RENAL DIALYSIS	111,518	2,254,403	0.049467		74
76 OP PSYCH	29,707	3,303,263	0.008993		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
91 EMERGENCY	152,460	18,276,115	0.008342		91
92 OBSERVATION BEDS	65,643	8,767,100	0.007487		92
93 FAMILY PRACTICE	285,802	17,496,562	0.016335		93
93.01 CANCER CENTER	38,156	192,872	0.197831		93.01
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	1,418,752	228,153,201			200

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
08/27/2012 07:42

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

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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

VERSION: 2011.10
 08/27/2012 07:42

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 PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	40,781		16,767		30
31 INTENSIVE CARE UNIT	2,557		604		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	622		347		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	43,960		17,718		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0177) [] 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	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			HEALTH	MEDICAL	COST
	ANESTHETIST	SCHOOL		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
52	DELIVERY ROOM & LABOR ROOM					52
54	RADIOLOGY-DIAGNOSTIC					54
56	RADIOISOTOPE					56
57	COMPUTED TOMOGRAPHY (CT) SCAN					57
60	LABORATORY					60
62.30	BLOOD CLOTTING FOR HEMOPHILIA					62.30
65	RESPIRATORY THERAPY					65
66	PHYSICAL THERAPY					66
71	MEDICAL SUPPLIES CHRGED TO PA					71
72	IMPL. DEV. CHARGED TO PATIENT					72
73	DRUGS CHARGED TO PATIENTS					73
74	RENAL DIALYSIS					74
76	OP PSYCH					76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS						
91	EMERGENCY					91
92	OBSERVATION BEDS					92
93	FAMILY PRACTICE					93
93.01	CANCER CENTER					93.01
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 (14-0177)	[]	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	9,156,454						50			
52 DELIVERY ROOM & LABOR ROOM	946,552						52			
54 RADIOLOGY-DIAGNOSTIC	14,674,714						54			
56 RADIOISOTOPE	1,527,630						56			
57 COMPUTED TOMOGRAPHY (CT) SCA	24,589,698						57			
60 LABORATORY	73,954,788						60			
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30			
65 RESPIRATORY THERAPY	20,607,929						65			
66 PHYSICAL THERAPY	2,971,825						66			
71 MEDICAL SUPPLIES CHRGED TO P	1,582,950						71			
72 IMPL. DEV. CHARGED TO PATIEN	401,845						72			
73 DRUGS CHARGED TO PATIENTS	27,448,501						73			
74 RENAL DIALYSIS	2,254,403						74			
76 OP PSYCH	3,303,263						76			
76.97 CARDIAC REHABILITATION							76.97			
76.98 HYPERBARIC OXYGEN THERAPY							76.98			
76.99 LITHOTRIPSY							76.99			
OUTPATIENT SERVICE COST CENTERS										
91 EMERGENCY	18,276,115						91			
92 OBSERVATION BEDS	8,767,100						92			
93 FAMILY PRACTICE	17,496,562						93			
93.01 CANCER CENTER	192,872						93.01			
OTHER REIMBURSABLE COST CENTERS										
200 TOTAL (SUM OF LINES 50-199)	228,153,201						200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0177) [] 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		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.335642					50
52	DELIVERY ROOM & LABOR ROOM	0.849851					52
54	RADIOLOGY-DIAGNOSTIC	0.171288					54
56	RADIOISOTOPE	0.240002					56
57	COMPUTED TOMOGRAPHY (CT) SCAN	0.042100					57
60	LABORATORY	0.076044					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	0.127095					65
66	PHYSICAL THERAPY	0.386120					66
71	MEDICAL SUPPLIES CHRGED TO PATI	0.411477					71
72	IMPL. DEV. CHARGED TO PATIENT	0.552332					72
73	DRUGS CHARGED TO PATIENTS	0.129223					73
74	RENAL DIALYSIS	0.462124					74
76	OP PSYCH	0.374146					76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
91	EMERGENCY	0.411247					91
92	OBSERVATION BEDS	0.198823					92
93	FAMILY PRACTICE	0.327004					93
93.01	CANCER CENTER	1.412025					93.01
OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (SEE INSTRUCTIONS)						200
201	LESS PBP CLINIC LAB SERVICES						201
202	NET CHARGES (LINE 200 - LINE 201)						202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK TITLE V-INPT HOSPITAL (14-0177) SUB (OTHER) ICF/MR PPS
 APPLICABLE 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)	40,781	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	40,781	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	38,547	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)	12,000	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)	31,819,596	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	31,819,596	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	57,492,307	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	57,492,307	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.553458	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)	1,491.49	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)	31,819,596	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0177) [] 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) 780.26 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 9,363,120 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) 9,363,120 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	4,402,458	2,557	1,721.73	1,287	2,215,867	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)					7,553,266	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					19,132,253	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 393,358 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 262,291 51
 52 TOTAL PROGRAM EXCLUDABLE COST 655,649 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 18,476,604 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) 2,234 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 780.26 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 1,743,101 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	
90 CAPITAL-RELATED COST	1,198,297	31,819,596	0.037659	1,743,101	65,643	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0177) [] 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)	40,781	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	40,781	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	38,547	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)	16,767	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)	622	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	347	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)	31,819,596	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	31,819,596	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	57,492,307	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	57,492,307	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.553458	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)	1,491.49	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)	31,819,596	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0177) [] 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) 780.26 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 13,082,619 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) 13,082,619 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)	1,071,533	622	1,722.72	347	597,784 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 4,402,458 2,557 1,721.73 604 1,039,925 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) 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 14,720,328 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 529,378 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 529,378 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 14,190,950 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) 2,234 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

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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
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 (14-0177)	[] 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	(COL.1 x COL.2)		
	1	2	3			
INPATIENT ROUTINE SERVICE COST CENTERS						
30		25,366,229		30		
31		4,444,596		31		
ANCILLARY SERVICE COST CENTERS						
50	0.335642	2,221,535	745,640	50		
52	0.849851	4,420	3,756	52		
54	0.171288	2,606,508	446,464	54		
56	0.240002	529,235	127,017	56		
57	0.042100	5,104,463	214,898	57		
60	0.076044	20,168,308	1,533,679	60		
62.30				62.30		
65	0.127095	7,576,422	962,925	65		
66	0.386120	598,089	230,934	66		
71	0.411477	401,937	165,388	71		
72	0.552332	285,192	157,521	72		
73	0.129223	9,159,740	1,183,649	73		
74	0.462124	1,034,880	478,243	74		
76	0.374146			76		
76.97				76.97		
76.98				76.98		
76.99				76.99		
OUTPATIENT SERVICE COST CENTERS						
91	0.411247	2,852,489	1,173,078	91		
92	0.198823	654,222	130,074	92		
93	0.327004			93		
93.01	1.412025			93.01		
OTHER REIMBURSABLE COST CENTERS						
200		53,197,440	7,553,266	200		
201				201		
202		53,197,440		202		

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
 PERIOD FROM 04/01/2011 TO 03/31/2012

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VERSION: 2011.10
 08/27/2012 07:42

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK	<input type="checkbox"/>	TITLE V	<input checked="" type="checkbox"/>	HOSPITAL (14-0177)	<input type="checkbox"/>	SUB (OTHER)	<input type="checkbox"/>	S/B SNF	<input checked="" type="checkbox"/>	PPS
APPLICABLE	<input type="checkbox"/>	TITLE XVIII-PT A	<input type="checkbox"/>	IPF	<input type="checkbox"/>	SNF	<input type="checkbox"/>	S/B NF	<input type="checkbox"/>	TEFRA
BOXES	<input checked="" type="checkbox"/>	TITLE XIX	<input type="checkbox"/>	IRF	<input type="checkbox"/>	NF	<input type="checkbox"/>	ICF/MR	<input type="checkbox"/>	OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
43 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.335642			50
52 DELIVERY ROOM & LABOR ROOM	0.849851			52
54 RADIOLOGY-DIAGNOSTIC	0.171288			54
56 RADIOISOTOPE	0.240002			56
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.042100			57
60 LABORATORY	0.076044			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.127095			65
66 PHYSICAL THERAPY	0.386120			66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.411477			71
72 IMPL. DEV. CHARGED TO PATIENT	0.552332			72
73 DRUGS CHARGED TO PATIENTS	0.129223			73
74 RENAL DIALYSIS	0.462124			74
76 OP PSYCH	0.374146			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
91 EMERGENCY	0.411247			91
92 OBSERVATION BEDS	0.198823			92
93 FAMILY PRACTICE	0.327004			93
93.01 CANCER CENTER	1.412025			93.01
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0177)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	15,326,189	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	292,004	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS	818,911	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	202.33	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)	11.29	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)	11.29	9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS	15.99	10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)	11.29	12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	15.92	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO	13.80	14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	13.67	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	13.67	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.067563	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.054180	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.054180	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	470,775	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)	4.70	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)	470,775	29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.2662	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.4789	31
32	SUM OF LINES 30 AND 31	0.7451	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.5069	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	7,768,845	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)	23,857,813	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)	23,857,813	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	1,492,539	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0177)
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)	371,139	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)	25,721,491	59
60	PRIMARY PAYER PAYMENTS	3,517	60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	25,717,974	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,586,982	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	312,944	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	1,096,996	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	767,897	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	1,096,996	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	24,585,945	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	24,585,945	71
72	INTERIM PAYMENTS	24,745,392	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	-159,447	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	498,101	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

PROVIDER CCN: 14-0177 JACKSON PARK HOSPITAL
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VERSION: 2011.10
08/27/2012 07:42

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK
APPLICABLE BOX

HOSPITAL (14-0177) CAH

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	10,118 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	13,287 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	411 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	41,104 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	312,298,544 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	6,969,850 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30
31	OTHER ADJUSTMENTS (SPECIFY)	31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-0177) [] 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

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	33,490,961 8
9	ANCILLARY SERVICE CHARGES	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)	33,490,961 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 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	33,490,961 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	33,490,961 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 (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	40
41	INTERIM PAYMENTS	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 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			11.29 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 ADJUSTMENT 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)			11.29 5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			15.99 6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			11.29 7
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR	15.92		15.92 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	11.24		11.24 9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT	11.24		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)	11.29		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)	11.29		13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)	11.27		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	11.27		17
18	PER RESIDENT AMOUNT	108,372.14	102,728.90	18
19	APPROVED AMOUNT FOR RESIDENT COSTS	1,221,354		1,221,354 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 WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			4.70 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)			1,221,354 25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
		PART A	CARE	
26	INPATIENT DAYS	13,287	411	26
27	TOTAL INPATIENT DAYS	41,104	41,104	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.323253	0.009999	28
29	PROGRAM DIRECT GME AMOUNT	394,806	12,212	29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE		1,726	30
31	NET PROGRAM DIRECT GME AMOUNT			405,292 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)			2,254,403 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 × LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			19,132,253 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)			3,517 40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			19,128,736 41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			1,760,253 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			1,760,253 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			20,888,989 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.915733 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.084267 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			405,292 48
49	PART A MEDICARE GME PAYMENT (LINE 46 × LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			371,139 49
50	PART B MEDICARE GME PAYMENT (LINE 47 × LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			34,153 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 ADJUSTMENT 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 WEIGHTED 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	MANAGED	
26	INPATIENT DAYS	PART A	CARE	
27	TOTAL INPATIENT DAYS	17,371	486	26
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	41,104	41,104	27
29	PROGRAM DIRECT GME AMOUNT	0.422611	0.011824	28
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE			29
31	NET PROGRAM DIRECT GME AMOUNT			30
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			31
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 × 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 × LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 × 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	2,919,609			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	86,683,327			4
5	OTHER RECEIVABLES	3,331,436			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-38,415,315			6
7	INVENTORY	1,038,425			7
8	PREPAID EXPENSES	2,075,623			8
9	OTHER CURRENT ASSETS	32,022,762			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	89,655,867			11
FIXED ASSETS					
12	LAND	2,482,024			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	42,564,149			15
16	ACCUMULATED DEPRECIATION	-51,368,649			16
17	LEASEHOLD IMPROVEMENTS	8,211,030			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	23,563,154			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)	25,451,708			30
OTHER ASSETS					
31	INVESTMENTS	351,074			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	286,163			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	637,237			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	115,744,812			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	20,064,416			37
38	SALARIES, WAGES & FEES PAYABLE				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				43
44	OTHER CURRENT LIABILITIES				44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	20,064,416			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	12,207,377			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	12,207,377			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	32,271,793			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	83,473,019			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)	83,473,019			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	115,744,812			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		76,101,088							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		7,371,931							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		83,473,019							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)		83,473,019							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 PENSION ADJUSTMENT									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)		83,473,019							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	58,893,993		58,893,993	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)	58,893,993		58,893,993	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	26,016,978		26,016,978	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	26,016,978		26,016,978	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	84,910,971		84,910,971	17
18 ANCILLARY SERVICES	121,595,893		121,595,893	18
19 OUTPATIENT SERVICES		88,134,706	88,134,706	19
20 RHC				20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	206,506,864	88,134,706	294,641,570	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		86,286,896	29
30 ADD (SPECIFY)			30
31 BAD DEBTS	34,045,916		31
32			32
33			33
34			34
35 MISC			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		34,045,916	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)		120,332,812	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	294,641,570	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	189,185,943	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	105,455,627	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	120,332,812	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-14,877,185	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	38,150	6
7	INCOME FROM INVESTMENTS	5,545	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		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24			24
24.01	OTHER (PROVIDER TAX PROCEEDS)	16,716,949	24.01
24.08	OTHER (MISC REVENUE)	5,488,472	24.08
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	22,249,116	25
26	TOTAL (LINE 5 PLUS LINE 25)	7,371,931	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	7,371,931	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-017) [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	1,242,704	1
2	CAPITAL DRG OUTLIER PAYMENTS	4,029	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	112.31	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	13.67	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0349	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	43,370	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.2662	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.4789	8
9	SUM OF LINES 7 AND 8	0.7451	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1629	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	202,436	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	1,492,539	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 ((14-017) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	2
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
10	SUM OF LINES 7 AND 8	9
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
13	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- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
19					19
20					20
21					21
22					22
23					23
INPATIENT ROUTINE SERV COST CENTERS					
30					30
31					31
43					43
ANCILLARY SERVICE COST CENTERS					
50					50
52					52
54					54
56					56
57					57
60					60
62.30					62.30
65					65
66					66
71					71
72					72
73					73
74					74
76					76
76.97					76.97
76.98					76.98
76.99					76.99
OUTPATIENT SERVICE COST CENTERS					
91					91
92					92
93					93
93.01					93.01
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118					118
NONREIMBURSABLE COST CENTERS					
192					192
194					194
200					200
201					201
202					202
203					203
204					204
204					204