

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: _____ TIME: _____
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ROSELAND COMMUNITY HOSPITAL (14-0068) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2012 AND ENDING 03/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		727,292	-16,298		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF					5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC					10
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		727,292	-16,298		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: 45 W. 111TH STREET
 2 CITY: CHICAGO

STATE: IL

P.O.BOX:
 ZIP CODE: 60628-

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	ROSELAND COMMUNITY HOSPITAL	14-0068	16974	1	06/01/1966	N	P	O	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA									12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (MM/DD/YYYY) FROM: 04/01/2012 TO: 03/31/2013									20
21	TYPE OF CONTROL									21

INPATIENT PPS INFORMATION

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

		IN-STATE		OUT-OF-STATE		OUT-OF-STATE		MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6		
		MEDICAID PAID DAYS 1	ELIGIBLE UNPAID DAYS 2	MEDICAID PAID DAYS 3	ELIGIBLE UNPAID DAYS 4	MEDICAID ELIGIBLE DAYS 7	MEDICAID DAYS 8				
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	8,056	3,137		51			719	75	24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				1					26	
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				1					27	
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:			ENDING:			36	
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:			ENDING:			38	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)									1	2
										N	N 39

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 ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.3+COL.4) 5	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1+COL.2)	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/COL.3+COL.4)
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER?			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?			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 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 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- N	OCCUP- N	RESPI- N
		SICAL	ATIONAL	RATORY
				109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-18 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	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.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 1,333,812 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2	140
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: ROSELAND COMMUNITY HOSPITAL CONTRACTOR'S NAME: NGS GOVERNMENT SERVICES CONTRACTOR'S NUMBER: 06001			141
142	STREET: 45 W 111TH STREET P.O. BOX:			142
143	CITY: CHICAGO STATE: IL ZIP CODE: 60628			143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

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

	TITLE XVIII		TITLE	TITLE
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1		1	2	1	
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N			
2		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.	N		2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	N		4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
6		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	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	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	07/30/2013	Y	07/30/2013
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.	Y		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 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. N 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. N 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. N 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. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. N 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. Y 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. N 35

HOME OFFICE COSTS

- 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? Y/N DATE
 1 2
- 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. N 36
- 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 37
- 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. N 38
- 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. N 39

COST REPORT PREPARER CONTACT INFORMATION

- 41 FIRST NAME: PATRICK LAST NAME: SZAJKOVICS TITLE: SENIOR CONSULTANT 41
- 42 EMPLOYER: STRATEGIC REIMBURSEMENT, INC. 42
- 43 PHONE NUMBER: 630 530-7100 X111 E-MAIL ADDRESS: PATRICK.SZAJKOVICS@SRINC.ORG 43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE	COMPONENT	WKST A LINE NO.	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7	TOTAL ALL PATIENTS 8
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	135	49,275		5,077	7,944	18,344	1
2	HMO						2,992		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		135	49,275		5,077	7,944	18,344	7
8	INTENSIVE CARE UNIT	31	10	3,650		1,125	619	2,834	8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43					376	852	13
14	TOTAL (SEE INSTRUCTIONS)		145	52,925		6,202	8,939	22,030	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40							16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101							22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88							26
27	TOTAL (SUM OF LINES 14-26)		145						27
28	OBSERVATION BED DAYS							340	28
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)						107	114	32
33	LTCH NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	WKST A LINE NO. 1	--- FULL TIME EQUIVALENTS ---				----- DISCHARGES -----			TOTAL ALL PATIENTS 15
		TOTAL INTERNS & RESIDENTS 9	ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1 HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					1,126	1,773	4,297	1
2 HMO									2
3 HMO IPF									3
4 HMO IRF									4
5 HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6 HOSPITAL ADULTS & PEDS. SWING BED NF									6
7 TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8 INTENSIVE CARE UNIT	31								8
9 CORONARY CARE UNIT	32								9
10 BURN INTENSIVE CARE UNIT	33								10
11 SURGICAL INTENSIVE CARE UNIT	34								11
12 OTHER SPECIAL CARE (SPECIFY)	35								12
13 NURSERY	43								13
14 TOTAL (SEE INSTRUCTIONS)			442.73			1,126	1,773	4,297	14
15 CAH VISITS									15
16 SUBPROVIDER - IPF	40								16
17 SUBPROVIDER - IRF	41								17
18 SUBPROVIDER I	42								18
19 SKILLED NURSING FACILITY	44								19
20 NURSING FACILITY	45								20
21 OTHER LONG TERM CARE	46								21
22 HOME HEALTH AGENCY	101								22
23 ASC (DISTINCT PART)	115								23
24 HOSPICE (DISTINCT PART)	116								24
25 CMHC	99								25
26 RHC	88								26
27 TOTAL (SUM OF LINES 14-26)			442.73						27
28 OBSERVATION BED DAYS									28
29 AMBULANCE TRIPS									29
30 EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31 EMPLOYEE DISCOUNT DAYS-IRF									31
32 LABOR & DELIVERY DAYS (SEE INSTR.)									32
33 LTCH NON-COVERED DAYS									33

HOSPITAL 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 5	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	26,305,361		26,305,361	973,059.00	27.03	1
2	NON-PHYSICIAN ANESTHETIST PART A						2
3	NON-PHYSICIAN ANESTHETIST PART B						3
4	PHYSICIAN-PART A ADMINISTRATIVE						4
4.01	PHYSICIAN-PART A - TEACHING						4.01
5	PHYSICIAN-PART B	401,895		401,895	2,999.00	134.01	5
6	NON-PHYSICIAN-PART B						6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)						7.01
8	HOME OFFICE PERSONNEL						8
9	SNF						9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	22,311		22,311	1,593.00	14.01	10
OTHER WAGES & RELATED COSTS							
11	CONTRACT LABOR (SEE INSTRUCTIONS)	45,318		45,318	712.00	63.65	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)	4,621,030		4,621,030			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS	3,984		3,984			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	71,758		71,758			23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM) OVERHEAD COSTS - DIRECT SALARIES						25
26	EMPLOYEE BENEFITS						26
27	ADMINISTRATIVE & GENERAL	5,731,744		5,731,744	185,536.00	30.89	27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)	5,964		5,964	228.00	26.16	28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT	666,941		666,941	24,324.00	27.42	30
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING	681,347		681,347	56,884.00	11.98	32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY	678,527	-204,388	474,139	33,677.00	14.08	34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA		204,388	204,388	14,516.00	14.08	36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION	1,444,120		1,444,120	34,725.00	41.59	38
39	CENTRAL SERVICES AND SUPPLY	90,196		90,196	6,040.00	14.93	39
40	PHARMACY	460,174		460,174	15,000.00	30.68	40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	466,955		466,955	26,518.00	17.61	41
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	25,909,430		25,909,430	970,288.00	26.70	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	22,311		22,311	1,593.00	14.01	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	25,887,119		25,887,119	968,695.00	26.72	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	45,318		45,318	712.00	63.65	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	4,621,030		4,621,030		17.85	5
6	TOTAL (SUM OF LINES 3 THRU 5)	30,553,467		30,553,467	969,407.00	31.52	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	10,225,968		10,225,968	397,448.00	25.73	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 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	187,046 3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	1,435,675 8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	52,426 10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	26,794 11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	187,800 13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	517,676 15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	1,896,196 17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	371,821 19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	21,337 23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	4,696,771 24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

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	51,282	2
3	SUBPROVIDER - IPF	51,282	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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.334908	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				24,061,167	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				52,726,169	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				17,658,416	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.					8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)					19
			UNINSURED PATIENTS	INSURED PATIENTS		TOTAL
			1	2		3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	4,642,807			4,642,807	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,554,913			1,554,913	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				0	22
23	COST OF CHARITY CARE	1,554,913			1,554,913	23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				18,634,613	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				176,450	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				18,458,163	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				6,181,786	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				7,736,699	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				7,736,699	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		1,397,792	1,397,792	239,726	1
2	00200				8,718	2
3	00300					3
4	00400		4,696,771	4,696,771		4
5.01	00510	79,208	604,346	683,554		5.01
5.02	00520	419,156	439,318	858,474		5.02
5.03	00530	249,621	312,762	562,383		5.03
5.04	00550	711,917	234,805	946,722		5.04
5.05	00560	4,271,842	3,932,646	8,204,488	3,522,415	5.05
6	00600					6
7	00700	666,941	1,244,831	1,911,772		7
8	00800					8
9	00900					9
10	01000	681,347	548,823	1,230,170		10
11	01100	678,527	806,654	1,485,181	-447,371	11
12	01200				447,371	12
13	01300					13
14	01400	1,444,120	74,244	1,518,364		14
15	01500	90,196	448,754	538,950	-417,393	15
16	01600	460,174	1,621,701	2,081,875	-981,925	16
17	01700	466,955	370,246	837,201		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	7,785,128	1,361,734	9,146,862	-393,284	30
31	03100	1,421,777	110,964	1,532,741		31
43	04300	368,675	44,923	413,598		43
ANCILLARY SERVICE COST CENTERS						
50	05000	264,415	935,934	1,200,349	-191,917	50
51	05100		10,494	10,494	58,372	51
52	05200				393,284	52
53	05300		1,045,601	1,045,601		53
54	05400	1,281,446	1,221,231	2,502,677	-80,413	54
60	06000	1,016,873	1,581,947	2,598,820	-223,847	60
62.30	06250					62.30
63	06300				223,847	63
66	06600	37,088	278,731	315,819		66
69.01	06901	1,168,143	639,734	1,807,877		69.01
71	07100				514,202	71
72	07200				36,736	72
73	07300				1,062,338	73
74	07400		235,909	235,909		74
76.97	07697					76.97
76.98	07698	173,172	111,783	284,955		76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000	115,616	13,450	129,066		90
91	09100	2,430,713	1,624,807	4,055,520		91
92	09200					92
92.01	09201					92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113	11300		3,770,859	3,770,859	-3,770,859	113
118		26,283,050	29,721,794	56,004,844		118
NONREIMBURSABLE COST CENTERS						
190	19000	22,311	2,782	25,093		190
200		26,305,361	29,724,576	56,029,937		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	1,637,518		1,507,992	1
2	00200	8,718	-129,526	8,718	2
3	00300				3
4	00400	4,696,771	-40,350	4,656,421	4
5.01	00510	683,554		683,554	5.01
5.02	00520	858,474		858,474	5.02
5.03	00530	562,383		562,383	5.03
5.04	00550	946,722	-10,707	936,015	5.04
5.05	00560	11,726,903	-173,341	11,553,562	5.05
6	00600				6
7	00700	1,911,772		1,911,772	7
8	00800				8
9	00900	1,230,170		1,230,170	9
10	01000	1,037,810	-9,223	1,028,587	10
11	01100	447,371	-105,895	341,476	11
12	01200				12
13	01300	1,518,364	-1,935	1,516,429	13
14	01400	121,557		121,557	14
15	01500	1,099,950		1,099,950	15
16	01600	837,201	-1,553	835,648	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	8,753,578	-796,965	7,956,613	30
31	03100	1,532,741		1,532,741	31
43	04300	413,598		413,598	43
ANCILLARY SERVICE COST CENTERS					
50	05000	1,008,432	-184,925	823,507	50
51	05100	68,866		68,866	51
52	05200	393,284		393,284	52
53	05300	1,045,601	-999,833	45,768	53
54	05400	2,422,264	-662	2,421,602	54
60	06000	2,374,973	-52,087	2,322,886	60
62.30	06250				62.30
63	06300	223,847		223,847	63
66	06600	315,819	-30,000	285,819	66
69.01	06901	1,807,877	-216,000	1,591,877	69.01
71	07100	514,202		514,202	71
72	07200	36,736		36,736	72
73	07300	1,062,338		1,062,338	73
74	07400	235,909		235,909	74
76.97	07697				76.97
76.98	07698	284,955		284,955	76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	129,066		129,066	90
91	09100	4,055,520	-1,278,408	2,777,112	91
92	09200				92
92.01	09201				92.01
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		56,004,844	-4,031,410	51,973,434	118
NONREIMBURSABLE COST CENTERS					
190	19000	25,093		25,093	190
200		56,029,937	-4,031,410	51,998,527	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER 2	INCREASE		SALARY 4	OTHER 5
			LINE # 3			
1 CAPITAL RELATED INTEREST	A	CAP REL COSTS-BLDG & FIXT	1			196,635 1
500 TOTAL RECLASSIFICATIONS						196,635 500
CODE LETTER - A						
1 DELIVERY ROOM RECLASS	B	DELIVERY ROOM & LABOR ROOM	52		372,725	20,559 1
500 TOTAL RECLASSIFICATIONS					372,725	20,559 500
CODE LETTER - B						
1 PROPERTY INSURANCE RECLASS	C	CAP REL COSTS-BLDG & FIXT	1			43,091 1
2 PROPERTY INSURANCE RECLASS	C	CAP REL COSTS-MVBLE EQUIP	2			8,718 2
500 TOTAL RECLASSIFICATIONS						51,809 500
CODE LETTER - C						
1 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D	MEDICAL SUPPLIES CHRGED TO PA	71			514,202 1
2 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D	IMPL. DEV. CHARGED TO PATIENT	72			36,736 2
3 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D					
500 TOTAL RECLASSIFICATIONS						550,938 500
CODE LETTER - D						
1 DRUGS SOLD RECLASS	E	DRUGS CHARGED TO PATIENTS	73			1,062,338 1
2 DRUGS SOLD RECLASS						
500 TOTAL RECLASSIFICATIONS						1,062,338 500
CODE LETTER - E						
1 CAFETERIA RECLASS	H	CAFETERIA	11		204,388	242,983 1
500 TOTAL RECLASSIFICATIONS					204,388	242,983 500
CODE LETTER - H						
1 RECOVERY ROOM COSTS	J	RECOVERY ROOM	51		58,372	
500 TOTAL RECLASSIFICATIONS					58,372	500
CODE LETTER - J						
1 OPERATING INTEREST RECLASS	K	OTHER ADMINISTRATIVE AND GENE	5.05			447,957 1
500 TOTAL RECLASSIFICATIONS						447,957 500
CODE LETTER - K						
1 IDPA PROVIDER TAX RECLASS	L	OTHER ADMINISTRATIVE AND GENE	5.05			3,126,267 1
500 TOTAL RECLASSIFICATIONS						3,126,267 500
CODE LETTER - L						
1 BLOOD COSTS RECLASS	N	BLOOD STORING, PROCESSING & T	63			223,847 1
500 TOTAL RECLASSIFICATIONS						223,847 500
CODE LETTER - N						
GRAND TOTAL (INCREASES)					635,485	5,923,333

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 CAPITAL RELATED INTEREST	A	INTEREST EXPENSE	113		196,635	11 1
500 TOTAL RECLASSIFICATIONS					196,635	500
CODE LETTER - A						
1 DELIVERY ROOM RECLASS	B	ADULTS & PEDIATRICS	30	372,725	20,559	1
500 TOTAL RECLASSIFICATIONS				372,725	20,559	500
CODE LETTER - B						
1 PROPERTY INSURANCE RECLASS	C	OTHER ADMINISTRATIVE AND GENE	5.05		43,091	12 1
2 PROPERTY INSURANCE RECLASS	C	OTHER ADMINISTRATIVE AND GENE	5.05		8,718	12 2
500 TOTAL RECLASSIFICATIONS					51,809	500
CODE LETTER - C						
1 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D	CENTRAL SERVICES & SUPPLY	14		417,393	1
2 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D	OPERATING ROOM	50		96,809	2
3 MEDICAL SUPPLIES AND IMPLANTS RECLAS	D	OPERATING ROOM	50		36,736	3
500 TOTAL RECLASSIFICATIONS					550,938	500
CODE LETTER - D						
1 DRUGS SOLD RECLASS	E	PHARMACY	15		981,925	1
2 DRUGS SOLD RECLASS	E	RADIOLOGY-DIAGNOSTIC	54		80,413	2
500 TOTAL RECLASSIFICATIONS					1,062,338	500
CODE LETTER - E						
1 CAFETERIA RECLASS	H	DIETARY	10	204,388	242,983	1
500 TOTAL RECLASSIFICATIONS				204,388	242,983	500
CODE LETTER - H						
1 RECOVERY ROOM COSTS	J	OPERATING ROOM	50	58,372		1
500 TOTAL RECLASSIFICATIONS				58,372		500
CODE LETTER - J						
1 OPERATING INTEREST RECLASS	K	INTEREST EXPENSE	113		447,957	11 1
500 TOTAL RECLASSIFICATIONS					447,957	500
CODE LETTER - K						
1 IDPA PROVIDER TAX RECLASS	L	INTEREST EXPENSE	113		3,126,267	13 1
500 TOTAL RECLASSIFICATIONS					3,126,267	500
CODE LETTER - L						
1 BLOOD COSTS RECLASS	N	LABORATORY	60		223,847	1
500 TOTAL RECLASSIFICATIONS					223,847	500
CODE LETTER - N						
GRAND TOTAL (DECREASES)				635,485	5,923,333	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND	923,853	9,600		9,600		933,453	1
2 LAND IMPROVEMENTS	495,806					495,806	2
3 BUILDINGS AND FIXTURES	24,411,600	630,347		630,347		25,041,947	3
4 BUILDING IMPROVEMENTS	7,501,712	68,945		68,945	198,538	7,372,119	4
5 FIXED EQUIPMENT	772,588					772,588	5
6 MOVABLE EQUIPMENT	16,380,922	1,994,920		1,994,920		18,375,842	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	50,486,481	2,703,812		2,703,812	198,538	52,991,755	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	50,486,481	2,703,812		2,703,812	198,538	52,991,755	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(1)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,397,792						1,397,792
2 CAP REL COSTS-MVBLE EQUIP							
3 TOTAL (SUM OF LINES 1-2)	1,397,792						1,397,792

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	RATIOS		INSURANCE	TAXES	OTHER	TOTAL
			FOR RATIO (COL. 1 - COL. 2)	RATIO (SEE INSTR.)			CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	34,615,913		34,615,913	0.653232				1
2 CAP REL COSTS-MVBLE EQUIP	18,375,842		18,375,842	0.346768				2
3 TOTAL (SUM OF LINES 1-2)	52,991,755		52,991,755	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL(2)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,397,792	-98,712	165,821	43,091			1,507,992
2 CAP REL COSTS-MVBLE EQUIP				8,718			8,718
3 TOTAL	1,397,792	-98,712	165,821	51,809			1,516,710

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)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-3,558,218			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-105,895	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1,553	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES	B	-9,223	DIETARY	10	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41 RCH SUITE RENTAL	B	-98,712	CAP REL COSTS-BLDG & FIXT	1	10 41
42 CPR TRAINING	B	-1,935	NURSING ADMINISTRATION	13	42
43					43
44					44
45 INVESTMENT INCOME INTEREST FUND	B	-2,567	OTHER ADMINISTRATIVE AND GENERA	5.05	45
45.02 FILM COPIES	B	-132	RADIOLOGY-DIAGNOSTIC	54	45.02
45.03 SALE OF SILVER	B	-530	RADIOLOGY-DIAGNOSTIC	54	45.03
45.04 REMAINING NON OPERATING REVENUE	B	-147,251	OTHER ADMINISTRATIVE AND GENERA	5.05	45.04
45.05 PATIENT ACCTG BILL COPIES	B	-10,707	CASHIERING/ACCOUNTS RECEIVABLE	5.04	45.05
45.07 MEDICARE ADJ-BOND AMORTIZATION	A	-30,814	CAP REL COSTS-BLDG & FIXT	1	11 45.07
45.08 MEDICARE ADJ-MEDICARE AFFAIRS CO	A	-23,523	OTHER ADMINISTRATIVE AND GENERA	5.05	45.08
45.09 HBP BENEFITS	A	-40,350	EMPLOYEE BENEFITS	4	45.09
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,031,410			50

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	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	30 ADULTS & PEDIATRICS	ADULTS & PEDIAT	796,965	796,965				1
2	53 ANESTHESIOLOGY	ANESTHESIOLOGY	999,833	999,833				2
3	91 EMERGENCY	EMERGENCY	1,278,408	1,278,408				3
4	60 LABORATORY	LABORATORY	52,087	52,087				4
6	50 OPERATING ROOM	OPERATING ROOM	124,925	124,925				6
7	69.01 CARDIOPULMONARY	CARDIOPULMONARY	216,000	216,000				7
8	50 OPERATING ROOM	OPERATING ROOM	60,000	60,000				8
9	66 PHYSICAL THERAPY	PHYSICAL THERAP	30,000	30,000				9
200	TOTAL		3,558,218	3,558,218				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.		12	13	14	15	16	17	18	
10	11								
1	30 ADULTS & PEDIATRICS							796,965	1
2	53 ANESTHESIOLOGY							999,833	2
3	91 EMERGENCY							1,278,408	3
4	60 LABORATORY							52,087	4
6	50 OPERATING ROOM							124,925	6
7	69.01 CARDIOPULMONARY							216,000	7
8	50 OPERATING ROOM							60,000	8
9	66 PHYSICAL THERAPY							30,000	9
200	TOTAL							3,558,218	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION	CAP	CAP	EMPLOYEE	NONPATIENT	
	(FROM WKST A, COL.7) 0	BLDGS & FIXTURES 1	MOVEABLE EQUIPMENT 2	BENEFITS 4	TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,507,992	1,507,992				1
2 CAP REL COSTS-MVBLE EQUIP	8,718		8,718			2
4 EMPLOYEE BENEFITS	4,656,421	11,734	22	4,668,177		4
5.01 NONPATIENT TELEPHONES	683,554			14,056	697,610	5.01
5.02 DATA PROCESSING	858,474	7,361	2,759	74,384	76,801	5.02
5.03 PURCHASING RECEIVING AND STORES	562,383	21,476	11	44,298	19,200	5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	936,015		113	126,338	36,267	5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	11,553,562	430,817	214	758,085	200,537	5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1,911,772	26,523	59	118,356	27,734	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	1,230,170	13,107	57	120,913	4,267	9
10 DIETARY	1,028,587	44,279	102	84,141	21,334	10
11 CAFETERIA	341,476			36,271		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,516,429		66	256,275	8,533	13
14 CENTRAL SERVICES & SUPPLY	121,557	26,656	74	16,006		14
15 PHARMACY	1,099,950	7,616		81,663	19,200	15
16 MEDICAL RECORDS & LIBRARY	835,648	17,468	120	82,866	32,000	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	7,956,613	392,869	2,230	1,315,414	57,601	30
31 INTENSIVE CARE UNIT	1,532,741	30,996	220	252,310	4,267	31
43 NURSERY	413,598	36,420	50	65,425		43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	823,507	80,677	781	36,565	59,734	50
51 RECOVERY ROOM	68,866	7,350	131	10,359		51
52 DELIVERY ROOM & LABOR ROOM	393,284	45,896	95	66,144		52
53 ANESTHESIOLOGY	45,768		150			53
54 RADIOLOGY-DIAGNOSTIC	2,421,602	47,933	1,069	227,407	34,134	54
60 LABORATORY	2,322,886	36,531		180,455	44,801	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	223,847					63
66 PHYSICAL THERAPY	285,819		74	6,582	19,200	66
69.01 CARDIOPULMONARY	1,591,877	12,310	177	207,300	23,467	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	514,202					71
72 IMPL. DEV. CHARGED TO PATIENT	36,736					72
73 DRUGS CHARGED TO PATIENTS	1,062,338		1			73
74 RENAL DIALYSIS	235,909					74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	284,955			30,731	2,133	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	129,066	40,073		20,517		90
91 EMERGENCY	2,777,112	166,048	143	431,357		91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	51,973,434	1,504,140	8,718	4,664,218	691,210	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,093	3,852		3,959	6,400	190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	51,998,527	1,507,992	8,718	4,668,177	697,610	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SSING	PURCHASING RECEIVING AND STORE	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (COLS. 0-4)	OTHER ADMI- NISTRATIVE AND GENER	
	5.02	5.03	5.04	4A	5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING	1,019,779					5.02
5.03 PURCHASING RECEIVING AND STORES	27,939	675,307				5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	90,802		1,189,535			5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	328,284			13,271,499	13,271,499	5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	13,970			2,098,414	719,112	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING				1,368,514	468,980	9
10 DIETARY	13,970			1,192,413	408,632	10
11 CAFETERIA				377,747	129,451	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION				1,781,303	610,440	13
14 CENTRAL SERVICES & SUPPLY	6,985			171,278	58,696	14
15 PHARMACY	27,939			1,236,368	423,695	15
16 MEDICAL RECORDS & LIBRARY	76,833			1,044,935	358,092	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	188,589	195,865	345,029	10,454,210	3,582,600	30
31 INTENSIVE CARE UNIT	6,985	35,012	61,672	1,924,203	659,411	31
43 NURSERY		2,868	5,051	523,412	179,370	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	13,970	12,003	21,142	1,048,379	359,272	50
51 RECOVERY ROOM		4,104	7,229	98,039	33,597	51
52 DELIVERY ROOM & LABOR ROOM		6,411	11,293	523,123	179,271	52
53 ANESTHESIOLOGY		7,818	13,771	67,507	23,134	53
54 RADIOLOGY-DIAGNOSTIC		50,695	89,296	2,872,136	984,261	54
60 LABORATORY	118,741	69,103	121,720	2,894,237	991,835	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.		7,552	13,303	244,702	83,858	63
66 PHYSICAL THERAPY		1,751	3,085	316,511	108,466	66
69.01 CARDIOPULMONARY	55,878	66,599	117,310	2,074,918	711,060	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		17,621	31,039	562,862	192,889	71
72 IMPL. DEV. CHARGED TO PATIENT		594	1,046	38,376	13,151	72
73 DRUGS CHARGED TO PATIENTS		66,113	116,454	1,244,906	426,621	73
74 RENAL DIALYSIS		3,896	6,862	246,667	84,531	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY		7,161	12,614	337,594	115,691	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		598	1,053	191,307	65,560	90
91 EMERGENCY	48,894	119,543	210,566	3,753,663	1,286,354	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,019,779	675,307	1,189,535	51,959,223	13,258,030	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				39,304	13,469	190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,019,779	675,307	1,189,535	51,998,527	13,271,499	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OPERATION	HOUSE-	DIETARY	CAFETERIA	NURSING	
	OF PLANT	KEEPING			ADMINIS-	
	7	9	10	11	TRATION	
					13	13
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,817,526					7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	36,560	1,874,054				9
10 DIETARY	123,513	32,363	1,756,921			10
11 CAFETERIA		32,363		539,561		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		16,182		30,308	2,438,233	13
14 CENTRAL SERVICES & SUPPLY	74,355	39,298		5,686		14
15 PHARMACY	21,244	16,182		13,000		15
16 MEDICAL RECORDS & LIBRARY	48,726	27,740		27,197		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	1,095,873	1,189,112	1,631,660	198,604	1,486,766	30
31 INTENSIVE CARE UNIT	86,459	27,740	125,261	35,708	267,315	31
43 NURSERY	101,590	16,182		7,510	56,221	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	225,041	84,375		6,205	46,449	50
51 RECOVERY ROOM	20,503	8,091				51
52 DELIVERY ROOM & LABOR ROOM	128,022	24,272				52
53 ANESTHESIOLOGY		3,467				53
54 RADIOLOGY-DIAGNOSTIC	133,703	62,415		45,722		54
60 LABORATORY	101,899	43,921		46,652		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
66 PHYSICAL THERAPY		11,558		2,128	12,717	66
69.01 CARDIOPULMONARY	34,337	20,111		36,692		69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		3,467				73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY				6,777		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	111,780	30,283		6,312		90
91 EMERGENCY	463,175	184,932		70,273	568,765	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,806,780	1,874,054	1,756,921	538,774	2,438,233	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,746			787		190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,817,526	1,874,054	1,756,921	539,561	2,438,233	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL					5.05
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	349,313				14
15 PHARMACY		1,710,489			15
16 MEDICAL RECORDS & LIBRARY			1,506,690		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	41,675		1,047,151	20,727,651	30
31 INTENSIVE CARE UNIT	15,524		94,921	3,236,542	31
43 NURSERY	8,375		72,321	964,981	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	74,851			1,844,572	50
51 RECOVERY ROOM	700			160,930	51
52 DELIVERY ROOM & LABOR ROOM	5,478			860,166	52
53 ANESTHESIOLOGY	3,981			98,089	53
54 RADIOLOGY-DIAGNOSTIC	28,169			4,126,406	54
60 LABORATORY				4,078,544	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRANS.				328,560	63
66 PHYSICAL THERAPY	504			451,884	66
69.01 CARDIOPULMONARY	31,554			2,908,672	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	69,899			825,650	71
72 IMPL. DEV. CHARGED TO PATIENT	22,740			74,267	72
73 DRUGS CHARGED TO PATIENTS		1,710,489		3,385,483	73
74 RENAL DIALYSIS				331,198	74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY				460,062	76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	6,783		27,120	439,145	90
91 EMERGENCY	39,080		265,177	6,631,419	91
92 OBSERVATION BEDS					92
92.01 23-HR OBSERVATION					92.01
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	349,313	1,710,489	1,506,690	51,934,221	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				64,306	190
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	349,313	1,710,489	1,506,690	51,998,527	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	NONPATIENT TELEPHONES		5.01
5.02	DATA PROCESSING		5.02
5.03	PURCHASING RECEIVING AND STORES		5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL		5.05
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	20,727,651	30
31	INTENSIVE CARE UNIT	3,236,542	31
43	NURSERY	964,981	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	1,844,572	50
51	RECOVERY ROOM	160,930	51
52	DELIVERY ROOM & LABOR ROOM	860,166	52
53	ANESTHESIOLOGY	98,089	53
54	RADIOLOGY-DIAGNOSTIC	4,126,406	54
60	LABORATORY	4,078,544	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	328,560	63
66	PHYSICAL THERAPY	451,884	66
69.01	CARDIOPULMONARY	2,908,672	69.01
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	825,650	71
72	IMPL. DEV. CHARGED TO PATIENT	74,267	72
73	DRUGS CHARGED TO PATIENTS	3,385,483	73
74	RENAL DIALYSIS	331,198	74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY	460,062	76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90	CLINIC	439,145	90
91	EMERGENCY	6,631,419	91
92	OBSERVATION BEDS		92
92.01	23-HR OBSERVATION		92.01
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	51,934,221	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64,306	190
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	51,998,527	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVEABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		11,734	22	11,756	11,756	4
5.01 NONPATIENT TELEPHONES					35	5.01
5.02 DATA PROCESSING		7,361	2,759	10,120	187	5.02
5.03 PURCHASING RECEIVING AND STORES		21,476	11	21,487	112	5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE			113	113	318	5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL		430,817	214	431,031	1,910	5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		26,523	59	26,582	298	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING		13,107	57	13,164	305	9
10 DIETARY		44,279	102	44,381	212	10
11 CAFETERIA					91	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			66	66	646	13
14 CENTRAL SERVICES & SUPPLY		26,656	74	26,730	40	14
15 PHARMACY		7,616		7,616	206	15
16 MEDICAL RECORDS & LIBRARY		17,468	120	17,588	209	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		392,869	2,230	395,099	3,308	30
31 INTENSIVE CARE UNIT		30,996	220	31,216	636	31
43 NURSERY		36,420	50	36,470	165	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		80,677	781	81,458	92	50
51 RECOVERY ROOM		7,350	131	7,481	26	51
52 DELIVERY ROOM & LABOR ROOM		45,896	95	45,991	167	52
53 ANESTHESIOLOGY			150	150		53
54 RADIOLOGY-DIAGNOSTIC		47,933	1,069	49,002	573	54
60 LABORATORY		36,531		36,531	455	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
66 PHYSICAL THERAPY			74	74	17	66
69.01 CARDIOPULMONARY		12,310	177	12,487	522	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS			1	1		73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY					77	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		40,073		40,073	52	90
91 EMERGENCY		166,048	143	166,191	1,087	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,504,140	8,718	1,512,858	11,746	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,852		3,852	10	190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,507,992	8,718	1,516,710	11,756	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NONPATIENT	DATA PROCES	PURCHASING	CASHIERING	OTHER ADMI	
	TELEPHONE S	SSING	RECEIVING AND STORE	/ACCOUNTS RECEIVABLE	NISTRATIVE AND GENER	
	5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES	35					5.01
5.02 DATA PROCESSING	4	10,311				5.02
5.03 PURCHASING RECEIVING AND STORES	1	282	21,882			5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE	2	918		1,351		5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	11	3,320			436,272	5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	1	141			23,639	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING					15,416	9
10 DIETARY	1	141			13,433	10
11 CAFETERIA					4,255	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION					20,066	13
14 CENTRAL SERVICES & SUPPLY		71			1,929	14
15 PHARMACY	1	282			13,928	15
16 MEDICAL RECORDS & LIBRARY	2	777			11,771	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	3	1,907	6,358	360	117,779	30
31 INTENSIVE CARE UNIT		71	1,134	72	21,676	31
43 NURSERY			93	6	5,896	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3	141	389	25	11,810	50
51 RECOVERY ROOM			133	8	1,104	51
52 DELIVERY ROOM & LABOR ROOM			208	13	5,893	52
53 ANESTHESIOLOGY			253	16	760	53
54 RADIOLOGY-DIAGNOSTIC	2		1,641	105	32,355	54
60 LABORATORY	2	1,201	2,237	143	32,604	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.			245	16	2,757	63
66 PHYSICAL THERAPY	1		57	4	3,565	66
69.01 CARDIOPULMONARY	1	565	2,156	138	23,374	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			571	36	6,341	71
72 IMPL. DEV. CHARGED TO PATIENT			19	1	432	72
73 DRUGS CHARGED TO PATIENTS			2,141	137	14,024	73
74 RENAL DIALYSIS			126	8	2,779	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY			232	15	3,803	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			19	1	2,155	90
91 EMERGENCY		494	3,870	247	42,285	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	35	10,311	21,882	1,351	435,829	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					443	190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35	10,311	21,882	1,351	436,272	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OPERATION	HOUSE-	DIETARY	CAFETERIA	NURSING	
	OF PLANT	KEEPING			ADMINIS-	
	7	9	10	11	TRATION	
					13	13
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	50,661					7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	657	29,542				9
10 DIETARY	2,221	510	60,899			10
11 CAFETERIA		510		4,856		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		255		273	21,306	13
14 CENTRAL SERVICES & SUPPLY	1,337	619		51		14
15 PHARMACY	382	255		117		15
16 MEDICAL RECORDS & LIBRARY	876	437		245		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	19,705	18,746	56,557	1,788	12,992	30
31 INTENSIVE CARE UNIT	1,555	437	4,342	321	2,336	31
43 NURSERY	1,827	255		68	491	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,046	1,330		56	406	50
51 RECOVERY ROOM	369	128				51
52 DELIVERY ROOM & LABOR ROOM	2,302	383				52
53 ANESTHESIOLOGY		55				53
54 RADIOLOGY-DIAGNOSTIC	2,404	984		411		54
60 LABORATORY	1,832	692		420		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
66 PHYSICAL THERAPY		182		19	111	66
69.01 CARDIOPULMONARY	617	317		330		69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		55				73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY				61		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	2,010	477		57		90
91 EMERGENCY	8,328	2,915		632	4,970	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	50,468	29,542	60,899	4,849	21,306	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	193			7		190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	50,661	29,542	60,899	4,856	21,306	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL					5.05
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	30,777				14
15 PHARMACY		22,787			15
16 MEDICAL RECORDS & LIBRARY			31,905		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	3,672		22,175	660,449	30
31 INTENSIVE CARE UNIT	1,368		2,010	67,174	31
43 NURSERY	738		1,531	47,540	43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	6,593			106,349	50
51 RECOVERY ROOM	62			9,311	51
52 DELIVERY ROOM & LABOR ROOM	483			55,440	52
53 ANESTHESIOLOGY	351			1,585	53
54 RADIOLOGY-DIAGNOSTIC	2,482			89,959	54
60 LABORATORY				76,117	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63 BLOOD STORING, PROCESSING & TRANS.				3,018	63
66 PHYSICAL THERAPY	44			4,074	66
69.01 CARDIOPULMONARY	2,780			43,287	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	6,159			13,107	71
72 IMPL. DEV. CHARGED TO PATIENT	2,004			2,456	72
73 DRUGS CHARGED TO PATIENTS		22,787		39,145	73
74 RENAL DIALYSIS				2,913	74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY				4,188	76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	598		574	46,016	90
91 EMERGENCY	3,443		5,615	240,077	91
92 OBSERVATION BEDS					92
92.01 23-HR OBSERVATION					92.01
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	30,777	22,787	31,905	1,512,205	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				4,505	190
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	30,777	22,787	31,905	1,516,710	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	NONPATIENT TELEPHONES		5.01
5.02	DATA PROCESSING		5.02
5.03	PURCHASING RECEIVING AND STORES		5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	OTHER ADMINISTRATIVE AND GENERAL		5.05
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	660,449	30
31	INTENSIVE CARE UNIT	67,174	31
43	NURSERY	47,540	43
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	106,349	50
51	RECOVERY ROOM	9,311	51
52	DELIVERY ROOM & LABOR ROOM	55,440	52
53	ANESTHESIOLOGY	1,585	53
54	RADIOLOGY-DIAGNOSTIC	89,959	54
60	LABORATORY	76,117	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,018	63
66	PHYSICAL THERAPY	4,074	66
69.01	CARDIOPULMONARY	43,287	69.01
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	13,107	71
72	IMPL. DEV. CHARGED TO PATIENT	2,456	72
73	DRUGS CHARGED TO PATIENTS	39,145	73
74	RENAL DIALYSIS	2,913	74
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY	4,188	76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90	CLINIC	46,016	90
91	EMERGENCY	240,077	91
92	OBSERVATION BEDS		92
92.01	23-HR OBSERVATION		92.01
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
113	INTEREST EXPENSE		113
118	SUBTOTALS (SUM OF LINES 1-117)	1,512,205	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,505	190
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	1,516,710	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVEABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	NONPATIENT TELEPHONE S PHONES	DATA PROCESsing MACH	
	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	136,225					1
2 CAP REL COSTS-MVBLE EQUIP		101,982				2
4 EMPLOYEE BENEFITS	1,060	252	26,305,361			4
5.01 NONPATIENT TELEPHONES			79,208	327		5.01
5.02 DATA PROCESSING	665	32,286	419,156	36	146	5.02
5.03 PURCHASING RECEIVING AND STORES	1,940	133	249,621	9	4	5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE		1,319	711,917	17	13	5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL	38,918	2,502	4,271,842	94	47	5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	2,396	694	666,941	13	2	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	1,184	664	681,347	2		9
10 DIETARY	4,000	1,188	474,139	10	2	10
11 CAFETERIA			204,388			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		775	1,444,120	4		13
14 CENTRAL SERVICES & SUPPLY	2,408	871	90,196		1	14
15 PHARMACY	688		460,174	9	4	15
16 MEDICAL RECORDS & LIBRARY	1,578	1,399	466,955	15	11	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	35,490	26,083	7,412,403	27	27	30
31 INTENSIVE CARE UNIT	2,800	2,575	1,421,777	2	1	31
43 NURSERY	3,290	585	368,675			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	7,288	9,141	206,043	28	2	50
51 RECOVERY ROOM	664	1,534	58,372			51
52 DELIVERY ROOM & LABOR ROOM	4,146	1,114	372,725			52
53 ANESTHESIOLOGY		1,749				53
54 RADIOLOGY-DIAGNOSTIC	4,330	12,509	1,281,446	16		54
60 LABORATORY	3,300		1,016,873	21	17	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
66 PHYSICAL THERAPY		863	37,088	9		66
69.01 CARDIOPULMONARY	1,112	2,066	1,168,143	11	8	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS		10				73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY			173,172	1		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	3,620		115,616			90
91 EMERGENCY	15,000	1,670	2,430,713		7	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	135,877	101,982	26,283,050	324	146	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	348		22,311	3		190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,507,992	8,718	4,668,177	697,610	1,019,779	202
203 UNIT COST MULT-WS B PT I	11.069862	0.085486	0.177461	2,133.363914	6,984.787671	203
204 COST TO BE ALLOC PER B PT II			11,756	35	10,311	204
205 UNIT COST MULT-WS B PT II			0.000447	0.107034	70.623288	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORE GROSS REVENUE 5.03	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE 5.04	RECON-CILIATION 5A.05	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.05	OPERATION OF PLANT SQUARE FEET 7	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	155,069,908					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE		155,069,908				5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL			-13,271,499	38,727,028		5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT				2,098,414	91,246	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING				1,368,514	1,184	9
10 DIETARY				1,192,413	4,000	10
11 CAFETERIA				377,747		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION				1,781,303		13
14 CENTRAL SERVICES & SUPPLY				171,278	2,408	14
15 PHARMACY				1,236,368	688	15
16 MEDICAL RECORDS & LIBRARY				1,044,935	1,578	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	44,979,281	44,979,281		10,454,210	35,490	30
31 INTENSIVE CARE UNIT	8,039,607	8,039,607		1,924,203	2,800	31
43 NURSERY	658,481	658,481		523,412	3,290	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,756,143	2,756,143		1,048,379	7,288	50
51 RECOVERY ROOM	942,341	942,341		98,039	664	51
52 DELIVERY ROOM & LABOR ROOM	1,472,200	1,472,200		523,123	4,146	52
53 ANESTHESIOLOGY	1,795,196	1,795,196		67,507		53
54 RADIOLOGY-DIAGNOSTIC	11,640,716	11,640,716		2,872,136	4,330	54
60 LABORATORY	15,867,552	15,867,552		2,894,237	3,300	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.	1,734,198	1,734,198		244,702		63
66 PHYSICAL THERAPY	402,136	402,136		316,511		66
69.01 CARDIOPULMONARY	15,292,610	15,292,610		2,074,918	1,112	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	4,046,229	4,046,229		562,862		71
72 IMPL. DEV. CHARGED TO PATIENT	136,381	136,381		38,376		72
73 DRUGS CHARGED TO PATIENTS	15,181,021	15,181,021		1,244,906		73
74 RENAL DIALYSIS	894,595	894,595		246,667		74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	1,644,330	1,644,330		337,594		76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	137,283	137,283		191,307	3,620	90
91 EMERGENCY	27,449,608	27,449,608		3,753,663	15,000	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	155,069,908	155,069,908	-13,271,499	38,687,724	90,898	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				39,304	348	190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	675,307	1,189,535		13,271,499	2,817,526	202
203 UNIT COST MULT-WS B PT I	0.004355	0.007671		0.342693	30.878351	203
204 COST TO BE ALLOC PER B PT II	21,882	1,351		436,272	50,661	204
205 UNIT COST MULT-WS B PT II	0.000141	0.000009		0.011265	0.555213	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION DIRECT NRSING	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
	HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	13	14	
	9	10	11			
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL						5.05
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	8,107					9
10 DIETARY	140	59,625				10
11 CAFETERIA	140		30,175			11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	70		1,695	18,215		13
14 CENTRAL SERVICES & SUPPLY	170		318		1,209,780	14
15 PHARMACY	70		727			15
16 MEDICAL RECORDS & LIBRARY	120		1,521			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	5,144	55,374	11,107	11,107	144,333	30
31 INTENSIVE CARE UNIT	120	4,251	1,997	1,997	53,766	31
43 NURSERY	70		420	420	29,004	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	365		347	347	259,233	50
51 RECOVERY ROOM	35				2,425	51
52 DELIVERY ROOM & LABOR ROOM	105				18,972	52
53 ANESTHESIOLOGY	15				13,786	53
54 RADIOLOGY-DIAGNOSTIC	270		2,557		97,558	54
60 LABORATORY	190		2,609			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRANS.						63
66 PHYSICAL THERAPY	50		119	95	1,746	66
69.01 CARDIOPULMONARY	87		2,052		109,281	69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					242,083	71
72 IMPL. DEV. CHARGED TO PATIENT					78,756	72
73 DRUGS CHARGED TO PATIENTS	15					73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY			379			76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	131		353		23,490	90
91 EMERGENCY	800		3,930	4,249	135,347	91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	8,107	59,625	30,131	18,215	1,209,780	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			44			190
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,874,054	1,756,921	539,561	2,438,233	349,313	202
203 UNIT COST MULT-WS B PT I	231.164919	29.466180	17.881060	133.858523	0.288741	203
204 COST TO BE ALLOC PER B PT II	29,542	60,899	4,856	21,306	30,777	204
205 UNIT COST MULT-WS B PT II	3.644011	1.021367	0.160928	1.169695	0.025440	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	
	COSTED REQUIS. 15	TIME SPENT 16	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5.01 NONPATIENT TELEPHONES			5.01
5.02 DATA PROCESSING			5.02
5.03 PURCHASING RECEIVING AND STORES			5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE			5.04
5.05 OTHER ADMINISTRATIVE AND GENERAL			5.05
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	1,000		15
16 MEDICAL RECORDS & LIBRARY		1,000	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		695	30
31 INTENSIVE CARE UNIT		63	31
43 NURSERY		48	43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
51 RECOVERY ROOM			51
52 DELIVERY ROOM & LABOR ROOM			52
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRANS.			63
66 PHYSICAL THERAPY			66
69.01 CARDIOPULMONARY			69.01
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS	1,000		73
74 RENAL DIALYSIS			74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90 CLINIC		18	90
91 EMERGENCY		176	91
92 OBSERVATION BEDS			92
92.01 23-HR OBSERVATION			92.01
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
118 SUBTOTALS (SUM OF LINES 1-117)	1,000	1,000	118
NONREIMBURSABLE COST CENTERS			
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			190
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	1,710,489	1,506,690	202
203 UNIT COST MULT-WS B PT I	1,710.489000	1,506.690000	203
204 COST TO BE ALLOC PER B PT II	22,787	31,905	204
205 UNIT COST MULT-WS B PT II	22.787000	31.905000	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	20,727,651		20,727,651		20,727,651	30
31 INTENSIVE CARE UNIT	3,236,542		3,236,542		3,236,542	31
43 NURSERY	964,981		964,981		964,981	43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,844,572		1,844,572		1,844,572	50
51 RECOVERY ROOM	160,930		160,930		160,930	51
52 DELIVERY ROOM & LABOR ROOM	860,166		860,166		860,166	52
53 ANESTHESIOLOGY	98,089		98,089		98,089	53
54 RADIOLOGY-DIAGNOSTIC	4,126,406		4,126,406		4,126,406	54
60 LABORATORY	4,078,544		4,078,544		4,078,544	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	328,560		328,560		328,560	63
66 PHYSICAL THERAPY	451,884		451,884		451,884	66
69.01 CARDIOPULMONARY	2,908,672		2,908,672		2,908,672	69.01
71 MEDICAL SUPPLIES CHRGD TO	825,650		825,650		825,650	71
72 IMPL. DEV. CHARGED TO PATIE	74,267		74,267		74,267	72
73 DRUGS CHARGED TO PATIENTS	3,385,483		3,385,483		3,385,483	73
74 RENAL DIALYSIS	331,198		331,198		331,198	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	460,062		460,062		460,062	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	439,145		439,145		439,145	90
91 EMERGENCY	6,631,419		6,631,419		6,631,419	91
92 OBSERVATION BEDS	377,189		377,189		377,189	92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	52,311,410		52,311,410		52,311,410	200
201 LESS OBSERVATION BEDS	377,189		377,189		377,189	201
202 TOTAL (SEE INSTRUCTIONS)	51,934,221		51,934,221		51,934,221	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	44,727,875		44,727,875			30
31 INTENSIVE CARE UNIT	8,039,607		8,039,607			31
43 NURSERY	658,481		658,481			43
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,978,620	777,523	2,756,143	0.669258	0.669258	0.669258 50
51 RECOVERY ROOM	543,312	399,029	942,341	0.170777	0.170777	0.170777 51
52 DELIVERY ROOM & LABOR ROOM	1,109,995	362,205	1,472,200	0.584273	0.584273	0.584273 52
53 ANESTHESIOLOGY	1,219,225	575,971	1,795,196	0.054640	0.054640	0.054640 53
54 RADIOLOGY-DIAGNOSTIC	4,226,607	7,414,109	11,640,716	0.354480	0.354480	0.354480 54
60 LABORATORY	7,970,380	7,897,172	15,867,552	0.257037	0.257037	0.257037 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
63 BLOOD STORING, PROCESSING &	1,380,213	353,985	1,734,198	0.189459	0.189459	0.189459 63
66 PHYSICAL THERAPY	280,443	121,693	402,136	1.123709	1.123709	1.123709 66
69.01 CARDIOPULMONARY	12,957,109	2,335,501	15,292,610	0.190201	0.190201	0.190201 69.01
71 MEDICAL SUPPLIES CHRGD TO	2,136,862	1,909,367	4,046,229	0.204054	0.204054	0.204054 71
72 IMPL. DEV. CHARGED TO PATIE	121,393	14,988	136,381	0.544555	0.544555	0.544555 72
73 DRUGS CHARGED TO PATIENTS	12,906,070	2,274,951	15,181,021	0.223008	0.223008	0.223008 73
74 RENAL DIALYSIS	877,819	16,776	894,595	0.370221	0.370221	0.370221 74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	956	1,643,374	1,644,330	0.279787	0.279787	0.279787 76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		137,283	137,283	3.198830	3.198830	3.198830 90
91 EMERGENCY	6,446,676	21,002,932	27,449,608	0.241585	0.241585	0.241585 91
92 OBSERVATION BEDS	3,484	247,922	251,406	1.500318	1.500318	1.500318 92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	107,585,127	47,484,781	155,069,908			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	107,585,127	47,484,781	155,069,908			202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3		4		5	6
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	660,449		660,449	18,684	35.35	5,077	179,472	30
31 INTENSIVE CARE UNIT	67,174		67,174	2,834	23.70	1,125	26,663	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	47,540		47,540	852	55.80			43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	775,163		775,163	22,370		6,202	206,135	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0068) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

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	106,349	2,756,143	0.038586	639,291	24,668	50
51 RECOVERY ROOM	9,311	942,341	0.009881	172,780	1,707	51
52 DELIVERY ROOM & LABOR ROOM	55,440	1,472,200	0.037658	4,492	169	52
53 ANESTHESIOLOGY	1,585	1,795,196	0.000883	353,682	312	53
54 RADIOLOGY-DIAGNOSTIC	89,959	11,640,716	0.007728	1,675,720	12,950	54
60 LABORATORY	76,117	15,867,552	0.004797	3,053,138	14,646	60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T	3,018	1,734,198	0.001740	447,619	779	63
66 PHYSICAL THERAPY	4,074	402,136	0.010131	141,718	1,436	66
69.01 CARDIOPULMONARY	43,287	15,292,610	0.002831	5,511,229	15,602	69.01
71 MEDICAL SUPPLIES CHRGED TO PA	13,107	4,046,229	0.003239	654,592	2,120	71
72 IMPL. DEV. CHARGED TO PATIENT	2,456	136,381	0.018008	40,228	724	72
73 DRUGS CHARGED TO PATIENTS	39,145	15,181,021	0.002579	4,305,895	11,105	73
74 RENAL DIALYSIS	2,913	894,595	0.003256	427,291	1,391	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	4,188	1,644,330	0.002547	440	1	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	46,016	137,283	0.335191			90
91 EMERGENCY	240,077	27,449,608	0.008746	2,192,550	19,176	91
92 OBSERVATION BEDS	12,018	251,406	0.047803			92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	749,060	101,643,945		19,620,665	106,786	200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL. 5 + COL. 6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL. 7 x COL. 8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	18,684		5,077		30
31 INTENSIVE CARE UNIT	2,834		1,125		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	852				43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	22,370		6,202		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0068) [] 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
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
66 PHYSICAL THERAPY						66
69.01 CARDIOPULMONARY						69.01
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
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 (14-0068)	[] 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 (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	2,756,143		639,291		110,923	50
51	RECOVERY ROOM	942,341		172,780		60,850	51
52	DELIVERY ROOM & LABOR ROOM	1,472,200		4,492		2,077	52
53	ANESTHESIOLOGY	1,795,196		353,682		66,832	53
54	RADIOLOGY-DIAGNOSTIC	11,640,716		1,675,720		828,910	54
60	LABORATORY	15,867,552		3,053,138		142,359	60
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
63	BLOOD STORING, PROCESSING &	1,734,198		447,619		20,443	63
66	PHYSICAL THERAPY	402,136		141,718		26,090	66
69.01	CARDIOPULMONARY	15,292,610		5,511,229		422,883	69.01
71	MEDICAL SUPPLIES CHRGED TO P	4,046,229		654,592		67,072	71
72	IMPL. DEV. CHARGED TO PATIEN	136,381		40,228		4,146	72
73	DRUGS CHARGED TO PATIENTS	15,181,021		4,305,895		242,050	73
74	RENAL DIALYSIS	894,595		427,291			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	1,644,330		440		451,530	76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	137,283				37	90
91	EMERGENCY	27,449,608		2,192,550		1,920,623	91
92	OBSERVATION BEDS	251,406				51,377	92
92.01	23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	101,643,945		19,620,665		4,418,202	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0068) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS			
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.669258	110,923			74,236			50
51 RECOVERY ROOM	0.170777	60,850			10,392			51
52 DELIVERY ROOM & LABOR ROOM	0.584273	2,077			1,214			52
53 ANESTHESIOLOGY	0.054640	66,832			3,652			53
54 RADIOLOGY-DIAGNOSTIC	0.354480	828,910			293,832			54
60 LABORATORY	0.257037	142,359			36,592			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63 BLOOD STORING, PROCESSING & TRA	0.189459	20,443			3,873			63
66 PHYSICAL THERAPY	1.123709	26,090			29,318			66
69.01 CARDIOPULMONARY	0.190201	422,883			80,433			69.01
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204054	67,072	3,693		13,686	754		71
72 IMPL. DEV. CHARGED TO PATIENT	0.544555	4,146			2,258			72
73 DRUGS CHARGED TO PATIENTS	0.223008	242,050			53,979			73
74 RENAL DIALYSIS	0.370221							74
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.279787	451,530			126,332			76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
90 CLINIC	3.198830	37			118			90
91 EMERGENCY	0.241585	1,920,623			463,994			91
92 OBSERVATION BEDS	1.500318	51,377			77,082			92
92.01 23-HR OBSERVATION								92.01
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)		4,418,202	3,693		1,270,991	754		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)		4,418,202	3,693		1,270,991	754		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3		4		5	6
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	660,449		660,449	18,684	35.35	7,944	280,820	30
31 INTENSIVE CARE UNIT	67,174		67,174	2,834	23.70	619	14,670	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	47,540		47,540	852	55.80	376	20,981	43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	775,163		775,163	22,370		8,939	316,471	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-0068) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [XX] OTHER

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	106,349	2,756,143	0.038586		50
51 RECOVERY ROOM	9,311	942,341	0.009881		51
52 DELIVERY ROOM & LABOR ROOM	55,440	1,472,200	0.037658		52
53 ANESTHESIOLOGY	1,585	1,795,196	0.000883		53
54 RADIOLOGY-DIAGNOSTIC	89,959	11,640,716	0.007728		54
60 LABORATORY	76,117	15,867,552	0.004797		60
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
63 BLOOD STORING, PROCESSING & T	3,018	1,734,198	0.001740		63
66 PHYSICAL THERAPY	4,074	402,136	0.010131		66
69.01 CARDIOPULMONARY	43,287	15,292,610	0.002831		69.01
71 MEDICAL SUPPLIES CHRGED TO PA	13,107	4,046,229	0.003239		71
72 IMPL. DEV. CHARGED TO PATIENT	2,456	136,381	0.018008		72
73 DRUGS CHARGED TO PATIENTS	39,145	15,181,021	0.002579		73
74 RENAL DIALYSIS	2,913	894,595	0.003256		74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY	4,188	1,644,330	0.002547		76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	46,016	137,283	0.335191		90
91 EMERGENCY	240,077	27,449,608	0.008746		91
92 OBSERVATION BEDS	12,018	251,406	0.047803		92
92.01 23-HR OBSERVATION					92.01
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	749,060	101,643,945			200

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] 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	18,684		7,944		30
31 INTENSIVE CARE UNIT	2,834		619		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	852		376		43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	22,370		8,939		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-0068) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS. 1-4)	COLS. 2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
51 RECOVERY ROOM						51
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
63 BLOOD STORING, PROCESSING & T						63
66 PHYSICAL THERAPY						66
69.01 CARDIOPULMONARY						69.01
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
74 RENAL DIALYSIS						74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
92.01 23-HR OBSERVATION						92.01
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 (14-0068)	[]	SUB (OTHER)	[]	ICF/MR	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[XX]	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	2,756,143						50			
51 RECOVERY ROOM	942,341						51			
52 DELIVERY ROOM & LABOR ROOM	1,472,200						52			
53 ANESTHESIOLOGY	1,795,196						53			
54 RADIOLOGY-DIAGNOSTIC	11,640,716						54			
60 LABORATORY	15,867,552						60			
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30			
63 BLOOD STORING, PROCESSING &	1,734,198						63			
66 PHYSICAL THERAPY	402,136						66			
69.01 CARDIOPULMONARY	15,292,610						69.01			
71 MEDICAL SUPPLIES CHRGED TO P	4,046,229						71			
72 IMPL. DEV. CHARGED TO PATIEN	136,381						72			
73 DRUGS CHARGED TO PATIENTS	15,181,021						73			
74 RENAL DIALYSIS	894,595						74			
76.97 CARDIAC REHABILITATION							76.97			
76.98 HYPERBARIC OXYGEN THERAPY	1,644,330						76.98			
76.99 LITHOTRIPSY							76.99			
OUTPATIENT SERVICE COST CENTERS										
90 CLINIC	137,283						90			
91 EMERGENCY	27,449,608						91			
92 OBSERVATION BEDS	251,406						92			
92.01 23-HR OBSERVATION							92.01			
OTHER REIMBURSABLE COST CENTERS										
200 TOTAL (SUM OF LINES 50-199)	101,643,945						200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-0068) [] 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	0.669258						50
51 RECOVERY ROOM	0.170777						51
52 DELIVERY ROOM & LABOR ROOM	0.584273						52
53 ANESTHESIOLOGY	0.054640						53
54 RADIOLOGY-DIAGNOSTIC	0.354480						54
60 LABORATORY	0.257037						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63 BLOOD STORING, PROCESSING & TRA	0.189459						63
66 PHYSICAL THERAPY	1.123709						66
69.01 CARDIOPULMONARY	0.190201						69.01
71 MEDICAL SUPPLIES CHRGED TO PATI	0.204054						71
72 IMPL. DEV. CHARGED TO PATIENT	0.544555						72
73 DRUGS CHARGED TO PATIENTS	0.223008						73
74 RENAL DIALYSIS	0.370221						74
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.279787						76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	3.198830						90
91 EMERGENCY	0.241585						91
92 OBSERVATION BEDS	1.500318						92
92.01 23-HR OBSERVATION							92.01
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 [XX] HOSPITAL (14-0068) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	18,684	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	18,684	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	18,344	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	5,077	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)	20,727,651	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	20,727,651	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	43,411,958	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	43,411,958	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.477464	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)	2,366.55	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)	20,727,651	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-0068) [] 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) 1,109.38 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 5,632,322 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) 5,632,322 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	3,236,542	2,834	1,142.04	1,125	1,284,795	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)					4,954,111	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					11,871,228	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 206,135 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 106,786 51
 52 TOTAL PROGRAM EXCLUDABLE COST 312,921 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 11,558,307 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) 340 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 1,109.38 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 377,189 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	660,449	20,727,651	0.031863	377,189	12,018	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 (14-0068) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	18,684	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	18,684	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	18,344	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	7,944	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)	852	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	376	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)	20,727,651	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	20,727,651	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	43,411,958	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	43,411,958	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	0.477464	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)	2,366.55	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)	20,727,651	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK	[]	TITLE V-INPT	[XX]	HOSPITAL (14-0068)	[]	SUB (OTHER)	[]	PPS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF			[]	TEFRA
BOXES	[XX]	TITLE XIX-INPT	[]	IRF			[XX]	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)				1,109.38	38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)				8,812,915	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)				8,812,915	41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)
	1	2	3	4	5
42 NURSERY (TITLES V AND XIX ONLY)	964,981	852	1,132.61	376	425,861
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	3,236,542	2,834	1,142.04	619	706,923
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)					9,945,699

PASS-THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III)					316,471
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					316,471
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52)					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)					340
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	ROUTINE COST (FROM LINE 27)	COL. 1 ÷ COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
		1	2	3	4	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 (14-0068) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		12,298,285		30
31 INTENSIVE CARE UNIT		3,415,240		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.669258	639,291	427,851	50
51 RECOVERY ROOM	0.170777	172,780	29,507	51
52 DELIVERY ROOM & LABOR ROOM	0.584273	4,492	2,625	52
53 ANESTHESIOLOGY	0.054640	353,682	19,325	53
54 RADIOLOGY-DIAGNOSTIC	0.354480	1,675,720	594,009	54
60 LABORATORY	0.257037	3,053,138	784,769	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63 BLOOD STORING, PROCESSING & TRA	0.189459	447,619	84,805	63
66 PHYSICAL THERAPY	1.123709	141,718	159,250	66
69.01 CARDIOPULMONARY	0.190201	5,511,229	1,048,241	69.01
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204054	654,592	133,572	71
72 IMPL. DEV. CHARGED TO PATIENT	0.544555	40,228	21,906	72
73 DRUGS CHARGED TO PATIENTS	0.223008	4,305,895	960,249	73
74 RENAL DIALYSIS	0.370221	427,291	158,192	74
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.279787	440	123	76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	3.198830			90
91 EMERGENCY	0.241585	2,192,550	529,687	91
92 OBSERVATION BEDS	1.500318			92
92.01 23-HR OBSERVATION				92.01
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		19,620,665	4,954,111	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		19,620,665		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-0068) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS
	1	2	(COL.1 x COL.2) 3
INPATIENT ROUTINE SERVICE COST CENTERS			
30 ADULTS & PEDIATRICS			30
31 INTENSIVE CARE UNIT			31
43 NURSERY			43
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM	0.669258		50
51 RECOVERY ROOM	0.170777		51
52 DELIVERY ROOM & LABOR ROOM	0.584273		52
53 ANESTHESIOLOGY	0.054640		53
54 RADIOLOGY-DIAGNOSTIC	0.354480		54
60 LABORATORY	0.257037		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
63 BLOOD STORING, PROCESSING & TRA	0.189459		63
66 PHYSICAL THERAPY	1.123709		66
69.01 CARDIOPULMONARY	0.190201		69.01
71 MEDICAL SUPPLIES CHRGD TO PATI	0.204054		71
72 IMPL. DEV. CHARGED TO PATIENT	0.544555		72
73 DRUGS CHARGED TO PATIENTS	0.223008		73
74 RENAL DIALYSIS	0.370221		74
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY	0.279787		76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90 CLINIC	3.198830		90
91 EMERGENCY	0.241585		91
92 OBSERVATION BEDS	1.500318		92
92.01 23-HR OBSERVATION			92.01
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 (14-0068)
 APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,308,200	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	178,475	2
2.01	OUTLIER RECONCILIATION AMOUNT		2.01
3	MANAGED CARE SIMULATED PAYMENTS		3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	144.07	4
INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS			
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR		13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3		15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT		18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)		19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)		21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)		22
INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON			
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)		29
DISPROPORTIONATE SHARE ADJUSTMENT			
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)	0.2122	30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)	0.5436	31
32	SUM OF LINES 30 AND 31	0.7558	32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.5157	33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)	3,768,839	34
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES			
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	11,255,514	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	11,255,514	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	682,653	50

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (14-0068)
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)		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)	11,938,167	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	11,938,167	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	754,655	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	130,494	63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	252,072	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	176,450	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	252,072	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	11,229,468	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
70.93	HVBP INCENTIVE PAYMENT (SEE INSTRUCTIONS)	-28,579	70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (SEE INSTRUCTIONS)	-31,821	70.94
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	11,169,068	71
72	INTERIM PAYMENTS	10,441,776	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	727,292	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	339,100	75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-0068) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		10,553,637		706,710	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		178,475		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	3.01
PROGRAM .01					3.02
TO .02					3.03
PROVIDER .03					3.04
TO .04					3.05
PROVIDER .05					3.06
TO .06					3.07
PROVIDER .07					3.08
TO .08					3.09
PROVIDER .09					3.50
TO .50	09/25/2012	290,336	09/25/2012	26,779	3.51
PROVIDER .51					3.52
TO .52					3.53
PROVIDER .53					3.54
TO .54					3.55
PROVIDER .55					3.56
TO .56					3.57
PROVIDER .57					3.58
TO .58					3.59
PROVIDER .59					3.99
TO .99					
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-290,336		-26,779	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		10,441,776		679,931	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	5.01
PROGRAM .01					5.02
TO .02					5.03
PROVIDER .03					5.04
TO .04					5.05
PROVIDER .05					5.06
TO .06					5.07
PROVIDER .07					5.08
TO .08					5.09
PROVIDER .09					5.50
TO .50					5.51
PROVIDER .51		NONE		NONE	5.52
TO .52					5.53
PROVIDER .53					5.54
TO .54					5.55
PROVIDER .55					5.56
TO .56					5.57
PROVIDER .57					5.58
TO .58					5.59
PROVIDER .59					5.99
TO .99					
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT		727,292		-16,298	6.01
PROGRAM .01					6.02
TO .02					
PROVIDER .03					
TO .04					
PROVIDER .05					
TO .06					
PROVIDER .07					
TO .08					
PROVIDER .09					
TO .50					
PROVIDER .51					
TO .52					
PROVIDER .53					
TO .54					
PROVIDER .55					
TO .56					
PROVIDER .57					
TO .58					
PROVIDER .59					
TO .99					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		11,169,068		663,633	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-0068) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	4,297	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	6,202	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	21,178	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	155,069,908	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	4,642,807	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 (14-0068) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1	9,945,699	1
2		2
3		3
4	9,945,699	4
5		5
6		6
7	9,945,699	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8		8
9		9
10		10
11		11
12		12
CUSTOMARY CHARGES		
13		13
14		14
15	1.000000	1.000000 15
16		16
17		17
18	9,945,699	18
19		19
20		20
21		21
PROSPECTIVE PAYMENT AMOUNT		
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43

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	668,804			1
2 TEMPORARY INVESTMENTS				2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	2,576,655			4
5 OTHER RECEIVABLES	463,896			5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	647,590			7
8 PREPAID EXPENSES	347,575			8
9 OTHER CURRENT ASSETS	1,788			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,706,308			11
FIXED ASSETS				
12 LAND	933,453			12
13 LAND IMPROVEMENTS	495,806			13
14 ACCUMULATED DEPRECIATION				14
15 BUILDINGS	26,885,133			15
16 ACCUMULATED DEPRECIATION	-26,598,933			16
17 LEASEHOLD IMPROVEMENTS	142,343			17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT	7,229,777			19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	19,148,430			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)	28,236,009			30
OTHER ASSETS				
31 INVESTMENTS	2,333,167			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS				34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	2,333,167			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	35,275,484			36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	11,590,216			37
38 SALARIES, WAGES & FEES PAYABLE	2,437,658			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	2,387,815			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	5,911,883			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	22,327,572			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	11,533,335			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	11,533,335			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	33,860,907			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	1,414,577			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)	1,414,577			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	35,275,484			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		2,308,706							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		77,474							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		2,386,180							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)		2,386,180							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 NET EQUITY ADJUSTMENTS		971,603							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		971,603							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		1,414,577							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	45,386,356		45,386,356	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)	45,386,356		45,386,356	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	8,039,607		8,039,607	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)	8,039,607		8,039,607	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	53,425,963		53,425,963	17
18 ANCILLARY SERVICES	54,135,296		54,135,296	18
19 OUTPATIENT SERVICES		47,651,492	47,651,492	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)	107,561,259	47,651,492	155,212,751	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		56,029,937	29
30 BAD DEBT EXPENSE	18,634,613		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		18,634,613	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)		74,664,550	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	155,212,751	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	87,922,322	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	67,290,429	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	74,664,550	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-7,374,121	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		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	OTHER (OTHER OPERATING REVENUE)	245,781	24
24.01	OTHER (OTHER NON OPERATING REVENUE)	150,284	24.01
24.02	OTHER (GRANT REVENUE)	7,055,530	24.02
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	7,451,595	25
26	TOTAL (LINE 5 PLUS LINE 25)	77,474	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)	77,474	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-006) [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	585,457	1
2	CAPITAL DRG OUTLIER PAYMENTS	361	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	58.02	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	0.2122	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	0.5436	8
9	SUM OF LINES 7 AND 8	0.7558	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	0.1654	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	96,835	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	682,653	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 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORE					5.03
5.04 CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 OTHER ADMINISTRATIVE AND GENER					5.05
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
51 RECOVERY ROOM					51
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
63 BLOOD STORING, PROCESSING & TR					63
66 PHYSICAL THERAPY					66
69.01 CARDIOPULMONARY					69.01
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
74 RENAL DIALYSIS					74
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
92.01 23-HR OBSERVATION					92.01
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

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

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	27.17		42.52				69.69 30
31 INTENSIVE CARE UNIT	39.70		21.84				61.54 31
43 NURSERY			44.13				44.13 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	23.20	4.02					27.22 50
51 RECOVERY ROOM	18.34	6.46					24.80 51
52 DELIVERY ROOM & LABOR ROOM	0.31	0.14					0.45 52
53 ANESTHESIOLOGY	19.70	3.72					23.42 53
54 RADIOLOGY-DIAGNOSTIC	14.40	7.12					21.52 54
60 LABORATORY	19.24	0.90					20.14 60
63 BLOOD STORING, PROCESSING & TRA	25.81	1.18					26.99 63
66 PHYSICAL THERAPY	35.24	6.49					41.73 66
69.01 CARDIOPULMONARY	36.04	2.77					38.81 69.01
71 MEDICAL SUPPLIES CHRGD TO PATI	16.18	1.75					17.93 71
72 IMPL. DEV. CHARGED TO PATIENT	29.50	3.04					32.54 72
73 DRUGS CHARGED TO PATIENTS	28.36	1.59					29.95 73
74 RENAL DIALYSIS	47.76						47.76 74
76.98 HYPERBARIC OXYGEN THERAPY	0.03	27.46					27.49 76.98
90 CLINIC		0.03					0.03 90
91 EMERGENCY	7.99	7.00					14.99 91
92 OBSERVATION BEDS		20.44					20.44 92
200 TOTAL CHARGES	19.30	4.35					23.65 200

COST CENTER	---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,507,992	2.90	-1,507,992	-5.23		1
2	CAP REL COSTS-MVBLE EQUIP	8,718	0.02	-8,718	-0.03		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	4,656,421	8.95	-4,656,421	-16.14		4
5.01	NONPATIENT TELEPHONES	683,554	1.31	-683,554	-2.37		5.01
5.02	DATA PROCESSING	858,474	1.65	-858,474	-2.98		5.02
5.03	PURCHASING RECEIVING AND STORES	562,383	1.08	-562,383	-1.95		5.03
5.04	CASHIERING/ACCOUNTS RECEIVABLE	936,015	1.80	-936,015	-3.24		5.04
5.05	OTHER ADMINISTRATIVE AND GENERA	11,553,562	22.22	-11,553,562	-40.04		5.05
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,911,772	3.68	-1,911,772	-6.63		7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING	1,230,170	2.37	-1,230,170	-4.26		9
10	DIETARY	1,028,587	1.98	-1,028,587	-3.56		10
11	CAFETERIA	341,476	0.66	-341,476	-1.18		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	1,516,429	2.92	-1,516,429	-5.26		13
14	CENTRAL SERVICES & SUPPLY	121,557	0.23	-121,557	-0.42		14
15	PHARMACY	1,099,950	2.12	-1,099,950	-3.81		15
16	MEDICAL RECORDS & LIBRARY	835,648	1.61	-835,648	-2.90		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCS-SALARY & FRINGES APP						21
22	I&R SRVCS-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	7,956,613	15.30	12,771,038	44.26	20,727,651	39.86
31	INTENSIVE CARE UNIT	1,532,741	2.95	1,703,801	5.91	3,236,542	6.22
43	NURSERY	413,598	0.80	551,383	1.91	964,981	1.86
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	823,507	1.58	1,021,065	3.54	1,844,572	3.55
51	RECOVERY ROOM	68,866	0.13	92,064	0.32	160,930	0.31
52	DELIVERY ROOM & LABOR ROOM	393,284	0.76	466,882	1.62	860,166	1.65
53	ANESTHESIOLOGY	45,768	0.09	52,321	0.18	98,089	0.19
54	RADIOLOGY-DIAGNOSTIC	2,421,602	4.66	1,704,804	5.91	4,126,406	7.94
60	LABORATORY	2,322,886	4.47	1,755,658	6.08	4,078,544	7.84
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRA	223,847	0.43	104,713	0.36	328,560	0.63
66	PHYSICAL THERAPY	285,819	0.55	166,065	0.58	451,884	0.87
69.01	CARDIOPULMONARY	1,591,877	3.06	1,316,795	4.56	2,908,672	5.59
71	MEDICAL SUPPLIES CHRGD TO PATI	514,202	0.99	311,448	1.08	825,650	1.59
72	IMPL. DEV. CHARGED TO PATIENT	36,736	0.07	37,531	0.13	74,267	0.14
73	DRUGS CHARGED TO PATIENTS	1,062,338	2.04	2,323,145	8.05	3,385,483	6.51
74	RENAL DIALYSIS	235,909	0.45	95,289	0.33	331,198	0.64
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY	284,955	0.55	175,107	0.61	460,062	0.88
76.99	LITHOTRIPSY						76.99
90	CLINIC	129,066	0.25	310,079	1.07	439,145	0.84
91	EMERGENCY	2,777,112	5.34	3,854,307	13.36	6,631,419	12.75
92	OBSERVATION BEDS						92
92.01	23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN	25,093	0.05	39,213	0.14	64,306	0.12
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	51,998,527	100.00			51,998,527	100.00

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	TOTAL	RATIO	INPATIENT	MEDICARE	
	RELATED		CAPITAL		PROGRAM	
	COSTS	CHARGES	COST TO	CHARGES	PPS CAPITAL	
	1	2	CHARGES	4	COSTS	5
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	106,349	2,756,143	0.038586	639,291	24,668	50
51 RECOVERY ROOM	9,311	942,341	0.009881	172,780	1,707	51
52 DELIVERY ROOM & LABOR ROOM	55,440	1,472,200	0.037658	4,492	169	52
53 ANESTHESIOLOGY	1,585	1,795,196	0.000883	353,682	312	53
54 RADIOLOGY-DIAGNOSTIC	89,959	11,640,716	0.007728	1,675,720	12,950	54
60 LABORATORY	76,117	15,867,552	0.004797	3,053,138	14,646	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63 BLOOD STORING, PROCESSING & TRA	3,018	1,734,198	0.001740	447,619	779	63
66 PHYSICAL THERAPY	4,074	402,136	0.010131	141,718	1,436	66
69.01 CARDIOPULMONARY	43,287	15,292,610	0.002831	5,511,229	15,602	69.01
71 MEDICAL SUPPLIES CHRGED TO PATI	13,107	4,046,229	0.003239	654,592	2,120	71
72 IMPL. DEV. CHARGED TO PATIENT	2,456	136,381	0.018008	40,228	724	72
73 DRUGS CHARGED TO PATIENTS	39,145	15,181,021	0.002579	4,305,895	11,105	73
74 RENAL DIALYSIS	2,913	894,595	0.003256	427,291	1,391	74
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY	4,188	1,644,330	0.002547	440	1	76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	46,016	137,283	0.335191			90
91 EMERGENCY	240,077	27,449,608	0.008746	2,192,550	19,176	91
92 OBSERVATION BEDS	12,018	251,406	0.047803			92
92.01 23-HR OBSERVATION						92.01
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL	749,060	101,643,945		19,620,665	106,786	200

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

COST CENTER DESCRIPTION	CAPITAL	SWING-BED	REDUCED	TOTAL	PER	INPATIENT	MEDICARE
	RELATED	ADJUSTMENT	CAPITAL	PATIENT			INPATIENT
	COSTS	AMOUNT	RELATED	DAYS	DIEM	PROGRAM	PPS CAPITAL
	1	2	COST	4	5	DAYS	COSTS
INPATIENT ROUTINE SERVICE COST CENTERS							
30 ADULTS & PEDIATRICS	660,449		660,449	18,684	35.35	5,077	179,472 30
31 INTENSIVE CARE UNIT	67,174		67,174	2,834	23.70	1,125	26,663 31
200 TOTAL	727,623		727,623	21,518		6,202	206,135 200
MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS							206,135
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS							106,786
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS							312,921
MEDICARE DISCHARGES (WKST S-3, PART I, LINE 14, COLUMN 13)							1,126
MEDICARE PATIENT DAYS (WKST S-3, PART I, LINE 14, COLUMN 6 - WKST S-3, PART I, LINE 5, COLUMN 6)							6,202
PER DISCHARGE CAPITAL COSTS							277.90
PER DIEM CAPITAL COSTS							50.45

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	11,558,307
2. HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-3 FOR HOSPITAL TITLE XVIII COMPONENT)	35,334,190
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.327

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 30-35, COLUMN 7 + WKST D PART II, LINE 200, COLUMN 5)	312,921
2. RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	0.009

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1 LESS LINES 61, 66-68, 74, 94, 95 & 96)	1,241,673
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 202, COLUMNS 2, 2.01, & 2.02 LESS LINES 61, 66-68, 74, 94, 95 & 96)	4,392,112
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	0.283

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3 Part IV, Line 4)

EXHIBIT 3

STEP 1: Determine the 3-Year Averaging Period		
1	Wage index fiscal year ending date	1
2	Provider's cost reporting period used for wage index year on Line 1 (FYB in Col 1, FYE in Col 2)	2
3	Midpoint of provider's cost reporting period shown on Line 2, adjusted to first of month	3
4	Date beginning the 3-year averaging period (subtract 18 months from midpoint shown on Line 3)	4
5	Date ending the 3-year averaging period (add 18 months to midpoint shown on Line 3)	5
STEP 2 (OPTIONAL): Adjust Averaging Period for a New Plan (SEE INSTRUCTIONS)		
6	Effective date of pension plan	6
7	First day of the provider cost reporting period containing the pension plan effective date	7
8	Starting date of the adjusted averaging period (date on Line 7, adjusted to first of month)	8
If this date occurs after the period shown on line 2, stop here and see instructions.		
STEP 3: Average Pension Contributions During the Averaging Period		
9	Beginning date of averaging period from Line 4 or Line 8, as applicable	9
10	Ending date of averaging period from Line 5	10
11	Enter provider contributions made during averaging period on Lines 9 & 10	11
11.01		11.01
12	Total calendar months included in averaging period (36 unless Step 2 completed)	12
13	Total contributions made during averaging period	13
14	Average monthly contribution (Line 13 divided by Line 12)	14
15	Number of months in provider cost reporting period on Line 2	15
16	Average pension contributions (Line 14 times Line 15)	16
STEP 4: Total Pension Cost for Wage Index		
17	Annual prefunding installment (SEE INSTRUCTIONS)	17
18	Reportable prefunding installment ((Line 17 times Line 15) divided by 12)	18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)	19