GOTTLIEB MEMORIAL HOSPITAL Provider CCN: 14-0008	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/29/2016 Run Time: 13:36 Version: 2016.05 (11/28/2016)

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. [X] Electronically filed cost report Date: 11/29/2016 Time: 13:36 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WERE 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 certification 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 GOTTLIEB MEMORIAL HOSPITAL (14-0008) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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 XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		492,526	288,586	454,113		1
2	SUBPROVIDER - IPF		23,802				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		26,850				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		543,178	288,586	454,113		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 resopnd 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.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 8700 WEST NORTH AVENUE	P.O. Box:			1
2	City: MELROSE PARK	State: IL	ZIP Code: 60160	County: COOK	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	GOTTLIEB MEMORIAL HOSPITAL	14-0008	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	14-S008	16974	4	01 / 01 / 2007	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF	GOTTLIEB SKILLED NURSING CARE	14-5526	16974		06 / 10 / 1985	N	P	O	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	GOTTLIEB HOME CARE	14-7255	16974		02 / 28 / 1984	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice	GOTTLIEB HOSPICE	14-1561	16974		01 / 01 / 2000				14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2015	To: 06 / 30 / 2016	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	967	1,111	3	11	3,056	126	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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 reseived 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				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. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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)				66

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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			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, indicate which program year began during this cost reporting period. (see instructions)	N			71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		V	XIX	
Title V and XIX Services		1	2	
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	Y	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/IID 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				1	2	
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? (see instructions)					106
107	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. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					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
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,854,529			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 high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		Y	5.00	122

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 cetfified 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 cetfified 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
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 (see instructions)	Y	HB1432	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: TRINITY HEALTH HOME OFFICE	Contractor's Name: WISCONSIN PHYSICIAN SERVICE Contractor's Number: 08201		141
142	Street: 20555 VICTORY PARKWAY	P.O. Box:		142
143	City: LIVONIA	State: MI	ZIP Code: 48152	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	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, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.25			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2015	06 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	10/15/2016	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/30/2016	Y	09/30/2016	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL 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 relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: DAVID	Last name: PALUCK	Title: REGIONAL DIR OF REIMBURSEM	41
42	Employer: LOYOLA UNIVERSITY HEALTH SYSTEM			42
43	Phone number: 708-216-6719	E-mail Address: DAVID.PALUCK@TRINITY-HEALTH.ORG		43

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

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	144	61,694			10,821	845	22,983	1
2	HMO and other (see instructions)						3,475	4,178		2
3	HMO IPF Subprovider						105			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 instructions)		144	61,694			10,821	845	22,983	7
8	Intensive Care Unit	31	24	3,624			1,007	96	2,362	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						155	1,528	13
14	Total (see instructions)		168	65,318			11,828	1,096	26,873	14
15	CAH Visits									15
16	Subprovider - IPF	40	12	4,392			2,985	5	3,155	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	34	12,444			7,206	101	9,562	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					377		1,277	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		214							27
28	Observation Bed Days							571	2,834	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								110	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		2	732					282	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								14	32.01
33	LTCH non-covered days									33

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

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					2,614	1,315	6,432	1
2	HMO and other (see instructions)					730			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 instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	4.49	734.75			2,614	1,315	6,432	14
15	CAH Visits								15
16	Subprovider - IPF		16.20			182		200	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		36.16						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		0.25						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)		0.01						24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	4.49	787.37						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	47,271,867		47,271,867	1,637,715.62	28.86	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative		229,227		229,227	1,160.00	197.61	4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44	2,092,149		2,092,149	75,203.91	27.82	9
10	Excluded area salaries (see instructions)		1,430,479		1,430,479	51,785.78	27.62	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		1,558,584		1,558,584	23,818.00	65.44	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs		3,077,972		3,077,972	36,844.00	83.54	14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		11,734,554		11,734,554			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		909,247		909,247			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative		47,762		47,762			22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		419,491		419,491	24,844.62	16.88	26
27	Administrative & General		3,915,227		3,915,227	175,180.18	22.35	27
28	Administrative & General under contract (see instructions)		182,613		182,613	4,886.00	37.37	28
29	Maintenance & Repairs		742,867		742,867	24,015.62	30.93	29
30	Operation of Plant		1,167,608		1,167,608	51,208.64	22.80	30
31	Laundry & Linen Service							31
32	Housekeeping		1,141,255		1,141,255	94,504.24	12.08	32
33	Housekeeping under contract (see instructions)		740,520		740,520	29,794.00	24.85	33
34	Dietary		777,326	-478,589	298,737	20,309.60	14.71	34
35	Dietary under contract (see instructions)		87,987		87,987	4,507.00	19.52	35
36	Cafeteria		162,333	478,589	640,922	44,684.33	14.34	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,788,864		1,788,864	38,782.10	46.13	38
39	Central Services and Supply		637,852		637,852	33,583.71	18.99	39
40	Pharmacy		2,100,955		2,100,955	49,088.00	42.80	40
41	Medical Records & Medical Records Library		1,284,248		1,284,248	56,739.33	22.63	41
42	Social Service		201,189		201,189	7,264.50	27.69	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		48,282,987		48,282,987	1,676,902.62	28.79	1
2	Excluded area salaries (see instructions)		3,522,628		3,522,628	126,989.69	27.74	2
3	Subtotal salarles (line 1 minus line 2)		44,760,359		44,760,359	1,549,912.93	28.88	3
4	Subtotal other wages & related costs (see instructions)		4,636,556		4,636,556	60,662.00	76.43	4
5	Subtotal wage-related costs (see instructions)		11,782,316		11,782,316		26.32%	5
6	Total (sum of lines 3 through 5)		61,179,231		61,179,231	1,610,574.93	37.99	6
7	Total overhead cost (see instructions)		15,350,335		15,350,335	659,391.87	23.28	7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	2,599,225	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	1,360,881	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)	3,903,362	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	131,691	10
11	Life Insurance (If employee is owner or beneficiary)	54,499	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	40,577	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	933,692	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	2,829,817	17
18	Medicare Taxes - Employers Portion Only	661,812	18
19	Unemployment Insurance	50,985	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	125,021	23
24	Total Wage Related cost (Sum of lines 1-23)	12,691,562	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		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 Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based 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-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7255** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County:

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours	24				24	1
2	Unduplicated Census Count (see instructions)		17.00				2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel	0.09		0.09	5
6	Direct Nursing Service	0.05		0.05	6
7	Nursing Supervisor	0.03		0.03	7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service	0.06		0.06	10
11	Occupational Therapy Supervisor	0.01		0.01	11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	16974	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	117		2	86	205	21
22	Skilled Nursing Visit Charges	24,241		407	17,906	42,554	22
23	Physical Therapy Visits	73			34	107	23
24	Physical Therapy Visit Charges	21,386			9,996	31,382	24
25	Occupational Therapy Visits	3				3	25
26	Occupational Therapy Visit Charges	720				720	26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits	9			3	12	29
30	Medical Social Service Visit Charges	2,739			913	3,652	30
31	Home Health Aide Visits	41			9	50	31
32	Home Health Aide Visit Charges	5,236			1,149	6,385	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	243		2	132	377	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	54,322		407	29,964	84,693	35
36	Total Number of Episodes (standard/non-outlier)	11		1	4	16	36
37	Total Number of Ourlier Episodes				1	1	37
38	Total Non-Routine Medical Supply Charges	2,182			991	3,173	38

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL	14		14	4
5	RVX				5
6	RVL	40		40	6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC	833		833	12
13	RUB	3,062		3,062	13
14	RUA	685		685	14
15	RVC	273		273	15
16	RVB	1,544		1,544	16
17	RVA	639		639	17
18	RHC				18
19	RHB	36		36	19
20	RHA	6		6	20
21	RMC				21
22	RMB	6		6	22
23	RMA	9		9	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2	10		10	35
36	HB1	9		9	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1	1		1	44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1	14		14	48
49	CC2				49
50	CC1	14		14	50
51	CB2				51
52	CB1	6		6	52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1	4		4	74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA	1		1	199
200	TOTAL	7,206		7,206	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training	318		Y	205
206	Other (NON-TRAINING EXPENSES)	3,557,336	49.14%	Y	206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	7,238,583			207

HOSPICE IDENTIFICATION DATA **HOSPICE CCN: 14-1561** **WORKSHEET S-9 PARTS I & II**

PART I - ENROLLMENT DAYS

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
1	Continuous Home Care							1
2	Routine Home Care	145	14			14	173	2
3	Inpatient Respite Care							3
4	General Inpatient Care							4
5	Total Hospice Days	145	14			14	173	5

PART II - CENSUS DATA

		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
6	Number of Patients Receiving Hospice Care	4	1			1	6	6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare							7
8	Average Length of Stay (line 5/line 6)	36.25	14.00			14.00	28.83	8
9	Unduplicated Census Count	1					1	9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in column 3 and 4.

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.202815	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	11,177,991	2
3	Did you receive DSH or supplemental payments from Medicaid?		3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	86,111,472	6
7	Medicaid cost (line 1 times line 6)	17,464,698	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.	6,286,707	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). 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 fundnig 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)	6,286,707	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		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	1,748,332	433,262	2,181,594	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	354,588	87,872	442,460	21
22	Partial payment by patients approved for charity care	404	23,408	23,812	22
23	Cost of charity care (line 21 minus line 22)	354,184	64,464	418,648	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)	7,844,515	26
27	Medicare bad debts for the entire hospital complex (see instructions)	670,431	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	7,174,084	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,455,012	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,873,660	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,160,367	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		8,911,667	8,911,667	-2,720,881	6,190,786	119,403	6,310,189	1
2	00200	Cap Rel Costs-Mvble Equip				3,276,573	3,276,573		3,276,573	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	419,491	11,421,852	11,841,343	-15,355	11,825,988	-429,585	11,396,403	4
5	00500	Administrative & General	3,915,227	17,155,669	21,070,896	-808,478	20,262,418	-12,750,392	7,512,026	5
6	00600	Maintenance & Repairs	742,867	2,537,401	3,280,268	-380	3,279,888		3,279,888	6
7	00700	Operation of Plant	1,167,608	2,940,611	4,108,219		4,108,219		4,108,219	7
8	00800	Laundry & Linen Service		719,797	719,797		719,797		719,797	8
9	00900	Housekeeping	1,141,255	1,613,874	2,755,129		2,755,129		2,755,129	9
10	01000	Dietary	777,326	1,374,547	2,151,873	-1,324,879	826,994	-83,843	743,151	10
11	01100	Cafeteria	162,333	4,623	166,956	1,324,879	1,491,835	-235,597	1,256,238	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,788,864	287,802	2,076,666		2,076,666	-1,826	2,074,840	13
14	01400	Central Services & Supply	637,852	504,762	1,142,614	-1,069	1,141,545		1,141,545	14
15	01500	Pharmacy	2,100,955	3,162,028	5,262,983	-938,537	4,324,446		4,324,446	15
16	01600	Medical Records & Library	1,284,248	685,596	1,969,844		1,969,844	-8,828	1,961,016	16
17	01700	Social Service	201,189	26,066	227,255		227,255		227,255	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd				342,786	342,786		342,786	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,265,460	1,214,812	10,480,272	-1,504,881	8,975,391		8,975,391	30
31	03100	Intensive Care Unit	2,544,337	673,641	3,217,978	-490,416	2,727,562		2,727,562	31
40	04000	Subprovider - IPF	918,859	32,347	951,206	-11,115	940,091		940,091	40
43	04300	Nursery				600,860	600,860		600,860	43
44	04400	Skilled Nursing Facility	2,092,149	1,465,505	3,557,654	-98,193	3,459,461		3,459,461	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,969,653	9,145,784	12,115,437	-7,887,324	4,228,113		4,228,113	50
51	05100	Recovery Room	396,640	194,819	591,459	-48,666	542,793		542,793	51
52	05200	Delivery Room & Labor Room	1,560,100	177,982	1,738,082	-116,939	1,621,143		1,621,143	52
53	05300	Anesthesiology		293,629	293,629	-235,483	58,146		58,146	53
54	05400	Radiology-Diagnostic	1,457,895	100,387	1,558,282	-62,761	1,495,521		1,495,521	54
56	05600	Radioisotope	197,591	224,507	422,098	-220,537	201,561		201,561	56
56.01	03630	ULTRASOUND	527,457	16,761	544,218	-35,240	508,978		508,978	56.01
57	05700	CT Scan	440,886	157,857	598,743	-87,651	511,092		511,092	57
58	05800	MRI	192,899	65,921	258,820	-33,881	224,939		224,939	58
59	05900	Cardiac Catheterization	588,154	1,225,843	1,813,997	-980,225	833,772		833,772	59
60	06000	Laboratory	2,245,770	2,441,903	4,687,673	-44,820	4,642,853		4,642,853	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	1,028,890	214,337	1,243,227	-123,160	1,120,067		1,120,067	65
66	06600	Physical Therapy	1,239,865	18,207	1,258,072	-13,952	1,244,120		1,244,120	66
67	06700	Occupational Therapy	249,426	1,304	250,730	-1,272	249,458		249,458	67
68	06800	Speech Pathology	203,205	61,693	264,898	-29,555	235,343		235,343	68
69	06900	Electrocardiology	406,529	73,778	480,307	-71,386	408,921		408,921	69
70	07000	Electroencephalography	91,594	9,432	101,026	-6,332	94,694		94,694	70
71	07100	Medical Supplies Charged to Patients				6,226,355	6,226,355		6,226,355	71
72	07200	Impl. Dev. Charged to Patients				5,728,194	5,728,194		5,728,194	72
73	07300	Drugs Charged to Patients				1,004,547	1,004,547		1,004,547	73
73.01	07301	OUTPATIENT PHARMACY								73.01
74	07400	Renal Dialysis				305,683	305,683		305,683	74
76	03950	LITHOTRIPSY								76
76.01	03951	CARDIAC REHABILITATION	217,230	4,959	222,189	-2,990	219,199		219,199	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	728,595	621,778	1,350,373	-334,875	1,015,498		1,015,498	76.02
76.05	03954	INPATIENT RENAL DIALYSIS								76.05
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic								90
90.01	09001	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	04950	WOUND CARE	331,223	501,052	832,275	-112,878	719,397	-36,960	682,437	90.02
90.03	09003	RIVER FOREST								90.03
91	09100	Emergency	2,526,625	1,181,582	3,708,207	-431,175	3,277,032	-4,024	3,273,008	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
101	10100	Home Health Agency		33,971	33,971	-10,617	23,354		23,354	101
		SPECIAL PURPOSE COST CENTERS								
116	11600	Hospice	1,280	4,523	5,803	-3,974	1,829		1,829	116
118		SUBTOTALS (sum of lines 1-117)	46,761,527	71,504,609	118,266,136		118,266,136	-13,431,652	104,834,484	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	27,235	67,434	94,669		94,669		94,669	190
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER								192.01
192.02	19202	OUTPATIENT PHARMACY	322,054	1,449,144	1,771,198		1,771,198		1,771,198	192.02
192.03	19203	WEST TOWN PHO								192.03
193	19300	Nonpaid Workers		26,564	26,564		26,564		26,564	193
193.01	19301	ADULT DAY CARE	161,051	18,804	179,855		179,855		179,855	193.01
200		TOTAL (sum of lines 118-199)	47,271,867	73,066,555	120,338,422		120,338,422	-13,431,652	106,906,770	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DRUGS CHARGED TO PATIENTS	A	Administrative & General	5		90,000	1
2	DRUGS CHARGED TO PATIENTS	A	Drugs Charged to Patients	73		1,004,547	2
3	DRUGS CHARGED TO PATIENTS	A					3
4	DRUGS CHARGED TO PATIENTS	A					4
5	DRUGS CHARGED TO PATIENTS	A					5
6	DRUGS CHARGED TO PATIENTS	A					6
7	DRUGS CHARGED TO PATIENTS	A					7
8	DRUGS CHARGED TO PATIENTS	A					8
9	DRUGS CHARGED TO PATIENTS	A					9
10	DRUGS CHARGED TO PATIENTS	A					10
11	DRUGS CHARGED TO PATIENTS	A					11
12	DRUGS CHARGED TO PATIENTS	A					12
13	DRUGS CHARGED TO PATIENTS	A					13
14	DRUGS CHARGED TO PATIENTS	A					14
15	DRUGS CHARGED TO PATIENTS	A					15
16	DRUGS CHARGED TO PATIENTS	A					16
17	DRUGS CHARGED TO PATIENTS	A					17
18	DRUGS CHARGED TO PATIENTS	A					18
19	DRUGS CHARGED TO PATIENTS	A					19
20	DRUGS CHARGED TO PATIENTS	A					20
21	DRUGS CHARGED TO PATIENTS	A					21
22	DRUGS CHARGED TO PATIENTS	A					22
23	DRUGS CHARGED TO PATIENTS	A					23
24	DRUGS CHARGED TO PATIENTS	A					24
25	DRUGS CHARGED TO PATIENTS	A					25
26	DRUGS CHARGED TO PATIENTS	A					26
27	DRUGS CHARGED TO PATIENTS	A					27
500	Total reclassifications					1,094,547	500
	Code Letter - A						
1	RENAL DIALYSIS PURCHASED SERVICES	B	Renal Dialysis	74		305,683	1
2	RENAL DIALYSIS PURCHASED SERVICES	B					2
500	Total reclassifications					305,683	500
	Code Letter - B						
1	DIETARY SHARED COST	C	Cafeteria	11	478,589	846,290	1
500	Total reclassifications				478,589	846,290	500
	Code Letter - C						
1	INTERNS AND RESIDENTS	E	I&R Services-Other Prgm Costs	22		342,786	1
500	Total reclassifications					342,786	500
	Code Letter - E						
1	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Medical Supplies Charged to P	71		6,239,295	1
2	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					2
3	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					3
4	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					4
5	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					5
6	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					6
7	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					7
8	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					8
9	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					9
10	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					10
11	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					11
12	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					12
13	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					13
14	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					14
15	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					15
16	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					16
17	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					17
18	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					18
19	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					19
20	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					20
21	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					21
22	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					22
23	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					23
24	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					24
25	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					25
26	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					26
27	MEDICAL SUPPLIES CHARGED TO PATIENTS	I					27
500	Total reclassifications					6,239,295	500
	Code Letter - I						
1	IMPLANTABLE DEVICES	L	Impl. Dev. Charged to Patient	72		5,728,194	1
2	IMPLANTABLE DEVICES	L					2
3	IMPLANTABLE DEVICES	L					3

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
4	IMPLANTABLE DEVICES	L					4
5	IMPLANTABLE DEVICES	L					5
6	IMPLANTABLE DEVICES	L					6
7	IMPLANTABLE DEVICES	L					7
8	IMPLANTABLE DEVICES	L					8
9	IMPLANTABLE DEVICES	L					9
10	IMPLANTABLE DEVICES	L					10
500	Total reclassifications					5,728,194	500
	Code Letter - L						
1	NURSERY	M	Nursery	43	568,101	32,759	1
2	NURSERY	M					2
500	Total reclassifications				568,101	32,759	500
	Code Letter - M						
1	CAPITAL MOVABLE EQUIPMENT	N	Cap Rel Costs-Mvble Equip	2		3,276,573	1
500	Total reclassifications					3,276,573	500
	Code Letter - N						
1	INTEREST EXPENSE	O	Cap Rel Costs-Bldg & Fixt	1		555,692	1
500	Total reclassifications					555,692	500
	Code Letter - O						
	GRAND TOTAL (Increases)				1,046,690	18,421,819	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DRUGS CHARGED TO PATIENTS	A	Employee Benefits Department	4		15,355		1
2	DRUGS CHARGED TO PATIENTS	A	Maintenance & Repairs	6		380		2
3	DRUGS CHARGED TO PATIENTS	A	Central Services & Supply	14		175		3
4	DRUGS CHARGED TO PATIENTS	A	Pharmacy	15		938,537		4
5	DRUGS CHARGED TO PATIENTS	A	Adults & Pediatrics	30		25,386		5
6	DRUGS CHARGED TO PATIENTS	A	Intensive Care Unit	31		7,667		6
7	DRUGS CHARGED TO PATIENTS	A	Subprovider - IPF	40		120		7
8	DRUGS CHARGED TO PATIENTS	A	Skilled Nursing Facility	44		804		8
9	DRUGS CHARGED TO PATIENTS	A	Operating Room	50		19,742		9
10	DRUGS CHARGED TO PATIENTS	A	Recovery Room	51		1,368		10
11	DRUGS CHARGED TO PATIENTS	A	Delivery Room & Labor Room	52		4,836		11
12	DRUGS CHARGED TO PATIENTS	A	Anesthesiology	53		9,198		12
13	DRUGS CHARGED TO PATIENTS	A	Radiology-Diagnostic	54		3,030		13
14	DRUGS CHARGED TO PATIENTS	A	Radioisotope	56		268		14
15	DRUGS CHARGED TO PATIENTS	A	ULTRASOUND	56.01		732		15
16	DRUGS CHARGED TO PATIENTS	A	CT Scan	57		104		16
17	DRUGS CHARGED TO PATIENTS	A	MRI	58		29,128		17
18	DRUGS CHARGED TO PATIENTS	A	Cardiac Catheterization	59		5,567		18
19	DRUGS CHARGED TO PATIENTS	A	Laboratory	60		17		19
20	DRUGS CHARGED TO PATIENTS	A	Physical Therapy	66		198		20
21	DRUGS CHARGED TO PATIENTS	A	Electrocardiology	69		127		21
22	DRUGS CHARGED TO PATIENTS	A	Electroencephalography	70		10		22
23	DRUGS CHARGED TO PATIENTS	A	GASTRO INTESTINAL SERVICES	76.02		3,169		23
24	DRUGS CHARGED TO PATIENTS	A	WOUND CARE	90.02		229		24
25	DRUGS CHARGED TO PATIENTS	A	Emergency	91		24,542		25
26	DRUGS CHARGED TO PATIENTS	A	Home Health Agency	101		1,290		26
27	DRUGS CHARGED TO PATIENTS	A	Hospice	116		2,568		27
500	Total reclassifications					1,094,547		500
	Code letter - A							
1	RENAL DIALYSIS PURCHASED SERVICES	B	Adults & Pediatrics	30		224,394		1
2	RENAL DIALYSIS PURCHASED SERVICES	B	Intensive Care Unit	31		81,289		2
500	Total reclassifications					305,683		500
	Code letter - B							
1	DIETARY SHARED COST	C	Dietary	10	478,589	846,290		1
500	Total reclassifications				478,589	846,290		500
	Code letter - C							
1	INTERNS AND RESIDENTS	E	Administrative & General	5		342,786		1
500	Total reclassifications					342,786		500
	Code letter - E							
1	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Adults & Pediatrics	30		667,178		1
2	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Intensive Care Unit	31		401,458		2
3	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Subprovider - IPF	40		10,995		3
4	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Skilled Nursing Facility	44		97,389		4
5	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Operating Room	50		2,414,508		5
6	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Recovery Room	51		47,298		6
7	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Delivery Room & Labor Room	52		111,619		7
8	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Anesthesiology	53		226,285		8
9	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Radiology-Diagnostic	54		59,731		9
10	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Radioisotope	56		220,269		10
11	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	ULTRASOUND	56.01		34,508		11
12	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	CT Scan	57		87,547		12
13	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	MRI	58		4,753		13
14	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Cardiac Catheterization	59		711,712		14
15	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Laboratory	60		44,681		15
16	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Respiratory Therapy	65		123,160		16
17	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Physical Therapy	66		13,754		17
18	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Occupational Therapy	67		1,272		18
19	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Speech Pathology	68		29,555		19
20	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Electrocardiology	69		71,259		20
21	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Electroencephalography	70		6,322		21
22	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	CARDIAC REHABILITATION	76.01		2,990		22
23	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	GASTRO INTESTINAL SERVICES	76.02		327,519		23
24	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	WOUND CARE	90.02		106,810		24
25	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Emergency	91		405,990		25
26	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Home Health Agency	101		9,327		26
27	MEDICAL SUPPLIES CHARGED TO PATIENTS	I	Hospice	116		1,406		27
500	Total reclassifications					6,239,295		500
	Code letter - I							
1	IMPLANTABLE DEVICES	L	Central Services & Supply	14		894		1
2	IMPLANTABLE DEVICES	L	Adults & Pediatrics	30		3		2

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
3	IMPLANTABLE DEVICES	L	Intensive Care Unit	31		2		3
4	IMPLANTABLE DEVICES	L	Operating Room	50		5,453,074		4
5	IMPLANTABLE DEVICES	L	Delivery Room & Labor Room	52		484		5
6	IMPLANTABLE DEVICES	L	Cardiac Catheterization	59		262,946		6
7	IMPLANTABLE DEVICES	L	Laboratory	60		122		7
8	IMPLANTABLE DEVICES	L	GASTRO INTESTINAL SERVICES	76.02		4,187		8
9	IMPLANTABLE DEVICES	L	WOUND CARE	90.02		5,839		9
10	IMPLANTABLE DEVICES	L	Emergency	91		643		10
500	Total reclassifications					5,728,194		500
	Code letter - L							
1	NURSERY	M	Adults & Pediatrics	30	568,101	19,819		1
2	NURSERY	M	Medical Supplies Charged to P	71		12,940		2
500	Total reclassifications				568,101	32,759		500
	Code letter - M							
1	CAPITAL MOVABLE EQUIPMENT	N	Cap Rel Costs-Bldg & Fixt	1		3,276,573	9	1
500	Total reclassifications					3,276,573		500
	Code letter - N							
1	INTEREST EXPENSE	O	Administrative & General	5		555,692	11	1
500	Total reclassifications					555,692		500
	Code letter - O							
	GRAND TOTAL (Decreases)				1,046,690	18,421,819		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS **WORKSHEET A-7 PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	12,500,000					12,500,000		1
2	Land Improvements	987,143					987,143		2
3	Buildings and Fixtures	50,780,098	4,084,951		4,084,951		54,865,049		3
4	Building Improvements								4
5	Fixed Equipment	8,419,145	2,440,695		2,440,695	658,624	10,201,216		5
6	Movable Equipment	31,438,287	10,128,780		10,128,780	658,624	40,908,443		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	104,124,673	16,654,426		16,654,426	1,317,248	119,461,851		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	104,124,673	16,654,426		16,654,426	1,317,248	119,461,851		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	8,911,667						8,911,667	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	8,911,667						8,911,667	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	68,352,192		68,352,192	0.611487					1
2	Cap Rel Costs-Mvble Equ	43,428,160		43,428,160	0.388513					2
3	Total (sum of lines 1-2)	111,780,352		111,780,352	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	5,635,094		675,095				6,310,189	1
2	Cap Rel Costs-Mvble Equip	3,276,573						3,276,573	2
3	Total (sum of lines 1-2)	8,911,667		675,095				9,586,762	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		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)	B	-5,083	Cap Rel Costs-Bldg & Fixt	1	11	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)	A	-92,579	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,715,284				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	1,303,642				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-230,301	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	-8,828	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-5,296	Cafeteria	11		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						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						32
33							33
34							34
35							35
35.07	MISC INCOME A&G	B	-5,372,827	Administrative & General	5		35.07
35.15	WEST TOWNS 958.729	A	-431,982	Administrative & General	5		35.15
35.19	EMPLOYEE DAY CARE REVENUE	B	-476,031	Employee Benefits Department	4		35.19
35.20	EMERGENCY ROOM - FFA REVENUE	B	-4,024	Emergency	91		35.20
36							36
37	DIETARY	B	-83,843	Dietary	10		37
38	AHA LOBBYING FEES	A	-21,732	Administrative & General	5		38
39							39
40							40
41	ADVERTISING	A	-30,383	Administrative & General	5		41
42	MISC NURSING DEVELOPMENT	B	-1,826	Nursing Administration	13		42
42.01	HAIP PROGRAM BENEFIT OFFSET	A	-4,255,275	Administrative & General	5		42.01
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,431,652				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	INTERCOMPANY LOAN AND CAP	674,109	555,692	118,417	11	1
2	5	Administrative & General	ADMIN OTHER OPERATING EXP	4,177,797	1,001,336	3,176,461		2
3	1	Cap Rel Costs-Bldg & Fixt	TIS CAPITAL EXPENSE	6,069		6,069	11	3
3.01	5	Administrative & General	TIS OPERATING EXPENSE	501,071		501,071		3.01
3.02	5	Administrative & General	MALPRACTICE INSURANCE	1,854,529	3,056,217	-1,201,688		3.02
3.03	4	Employee Benefits Department	WORKERS COMPENSATION INS	933,692	1,018,306	-84,614		3.03
3.04	5	Administrative & General	PROPERTY INSURANCE	169,602	129,004	40,598		3.04
3.05	5	Administrative & General	INTEGRATED RISK INSURANCE	196,078	266,768	-70,690		3.05
3.07	4	Employee Benefits Department	EMP HEALTH STOP LOSS		179,973	-179,973		3.07
3.08	4	Employee Benefits Department	RETIREMENT DEFD BENE	288,033	-23,000	311,033		3.08
3.09	5	Administrative & General	I/C THCE REPAIRS AND MAINT		1,313,042	-1,313,042		3.09
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,800,980	7,497,338	1,303,642		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			TRINITY HEALTH	100.00	HEALTHCARE SYSTEM	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 PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	90.02	WOUND CARE WOUND CARE	36,960	36,960						1
2	5	Administrative & Gen ADMINISTRATIVE	3,678,324	3,678,324						2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,715,284	3,715,284						200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	90.02	WOUND CARE WOUND CARE							36,960	1
2	5	Administrative & Gen ADMINISTRATIVE							3,678,324	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							3,715,284	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	6,310,189	6,310,189					1
2	Cap Rel Costs-Mvble Equip	3,276,573		3,276,573				2
4	Employee Benefits Department	11,396,403	10,661	19,320	11,426,384			4
5	Administrative & General	7,512,026	436,866	396,055	954,849	9,299,796	9,299,796	5
6	Maintenance & Repairs	3,279,888	26,420	124,620	181,171	3,612,099	344,154	6
7	Operation of Plant	4,108,219	1,526,336	151,255	284,757	6,070,567	578,391	7
8	Laundry & Linen Service	719,797	25,363			745,160	70,997	8
9	Housekeeping	2,755,129	23,602	6,107	278,330	3,063,168	291,853	9
10	Dietary	743,151	135,882	2,927	72,856	954,816	90,973	10
11	Cafeteria	1,256,238	119,826	17,667	156,309	1,550,040	147,685	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,074,840	38,397	121,660	436,270	2,671,167	254,503	13
14	Central Services & Supply	1,141,545	148,415	113,560	155,560	1,559,080	148,546	14
15	Pharmacy	4,324,446	50,856	185,752	512,383	5,073,437	483,387	15
16	Medical Records & Library	1,961,016	56,140		313,204	2,330,360	222,032	16
17	Social Service	227,255	30,239		49,066	306,560	29,208	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	342,786				342,786	32,660	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,975,391	1,120,764	173,136	2,121,101	12,390,392	1,180,529	30
31	Intensive Care Unit	2,727,562	203,944	148,551	620,515	3,700,572	352,583	31
40	Subprovider - IPF	940,091	93,017	1,391	224,092	1,258,591	119,916	40
43	Nursery	600,860	23,991		138,549	763,400	72,735	43
44	Skilled Nursing Facility	3,459,461	222,818	7,058	510,235	4,199,572	400,127	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,228,113	471,463	1,055,486	724,242	6,479,304	617,335	50
51	Recovery Room	542,793	28,126	97,908	96,733	765,560	72,941	51
52	Delivery Room & Labor Room	1,621,143	129,226	71,812	380,479	2,202,660	209,865	52
53	Anesthesiology	58,146	8,658	14,720		81,524	7,767	53
54	Radiology-Diagnostic	1,495,521	186,182	220,999	355,553	2,258,255	215,162	54
56	Radioisotope	201,561	35,264		48,189	285,014	27,156	56
56.01	ULTRASOUND	508,978	35,486	117,396	128,637	790,497	75,317	56.01
57	CT Scan	511,092	22,582	17,896	107,524	659,094	62,797	57
58	MRI	224,939	43,551	4,337	47,044	319,871	30,477	58
59	Cardiac Catheterization	833,772	38,249	4,601	143,440	1,020,062	97,189	59
60	Laboratory	4,642,853	182,029	44,951	547,701	5,417,534	516,172	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,120,067	20,265	27,638	250,927	1,418,897	135,190	65
66	Physical Therapy	1,244,120	152,031	1,081	302,380	1,699,612	161,936	66
67	Occupational Therapy	249,458	30,684		60,830	340,972	32,487	67
68	Speech Pathology	235,343	19,671	1,653	49,558	306,225	29,177	68
69	Electrocardiology	408,921	38,156	19,695	99,145	565,917	53,919	69
70	Electroencephalography	94,694	19,338		22,338	136,370	12,993	70
71	Medical Supplies Charged to Patients	6,226,355				6,226,355	593,235	71
72	Impl. Dev. Charged to Patients	5,728,194				5,728,194	545,771	72
73	Drugs Charged to Patients	1,004,547				1,004,547	95,711	73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis	305,683				305,683	29,125	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	219,199	66,912	1,117	52,978	340,206	32,414	76.01
76.02	GASTRO INTESTINAL SERVICES	1,015,498			177,690	1,193,188	113,685	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,706			1,706	163	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	682,437	38,156	1,298	80,779	802,670	76,477	90.02
90.03	RIVER FOREST							90.03
91	Emergency	3,273,008	250,424	104,893	616,196	4,244,521	404,409	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	23,354	81,188			104,542	9,961	101
	SPECIAL PURPOSE COST CENTERS							

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
116	Hospice	1,829			312	2,141	204	116
118	SUBTOTALS (sum of lines 1-117)	104,834,484	6,192,884	3,276,540	11,301,922	104,592,684	9,079,314	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	94,669	22,601		6,642	123,912	11,806	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	1,771,198	36,821	33	78,543	1,886,595	179,751	192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	26,564	28,589			55,153	5,255	193
193.01	ADULT DAY CARE	179,855	29,294		39,277	248,426	23,670	193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	106,906,770	6,310,189	3,276,573	11,426,384	106,906,770	9,299,796	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs	3,956,253						6
7	Operation of Plant	278,303	6,927,261					7
8	Laundry & Linen Service		40,766	856,923				8
9	Housekeeping	1,867,740	37,935	73,331	5,334,027			9
10	Dietary	5,854	218,402	4,103	144,049	1,418,197		10
11	Cafeteria	9,344	192,595	6,578	126,193		2,032,435	11
12	Maintenance of Personnel							12
13	Nursing Administration		61,715		11,034		66,159	13
14	Central Services & Supply		238,546		81,053		55,208	14
15	Pharmacy	924,976	81,740		64,200		87,652	15
16	Medical Records & Library		90,233		37,517		98,275	16
17	Social Service		48,603				12,797	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,801,393		2,092,524	827,495	469,676	30
31	Intensive Care Unit		327,796		224,700	85,039	95,773	31
40	Subprovider - IPF		149,505			111,696	57,464	40
43	Nursery		38,561		49,153	55,015	23,912	43
44	Skilled Nursing Facility		358,132		449,401	338,952	129,201	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	631,361	757,776	766,060	527,244		143,147	50
51	Recovery Room		45,206		50,959		16,899	51
52	Delivery Room & Labor Room		207,704		102,921		65,913	52
53	Anesthesiology		13,916		7,423			53
54	Radiology-Diagnostic		299,248		133,817		88,882	54
56	Radioisotope		56,679		53,166		7,916	56
56.01	ULTRASOUND		57,037		11,034		21,575	56.01
57	CT Scan		36,296	616	58,783		21,903	57
58	MRI		69,999	1,592			8,244	58
59	Cardiac Catheterization		61,477				21,985	59
60	Laboratory		292,573		196,813		144,869	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32,571		26,282		55,290	65
66	Physical Therapy		244,357		224,901		68,333	66
67	Occupational Therapy		49,318		45,341		10,418	67
68	Speech Pathology		31,617		29,091		11,813	68
69	Electrocardiology	116,748	61,328		56,978		25,102	69
70	Electroencephalography		31,081		5,818		5,742	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION		107,547		73,830		9,024	76.01
76.02	GASTRO INTESTINAL SERVICES	121,927					32,854	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		2,742					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE		61,328				17,432	90.02
90.03	RIVER FOREST							90.03
91	Emergency		402,504	4,643	190,995		127,396	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		130,493		247,572		492	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice				11,235		41	116
118	SUBTOTALS (sum of lines 1-117)	3,956,253	6,738,719	856,923	5,334,027	1,418,197	2,001,387	118

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		36,326				3,732	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY		59,182				16,365	192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers		45,951					193
193.01	ADULT DAY CARE		47,083				10,951	193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,956,253	6,927,261	856,923	5,334,027	1,418,197	2,032,435	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	
		13	14	15	16	17	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	3,064,578						13
14	Central Services & Supply		2,082,433					14
15	Pharmacy		253,791	6,969,183				15
16	Medical Records & Library	29,445	716		2,808,578			16
17	Social Service		113			397,281		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		234				375,680	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,330,085	9,886		448,437	252,293	3,757	30
31	Intensive Care Unit	303,305	3,295		119,421	26,050		31
40	Subprovider - IPF	143,835	1,002		171,088	96,765		40
43	Nursery	69,703	1,812		17,060			43
44	Skilled Nursing Facility	316,724	2,905					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	218,359	81,591		449,899			50
51	Recovery Room	42,213	308		22,422			51
52	Delivery Room & Labor Room	183,182	1,902		35,095			52
53	Anesthesiology		5,637		45,819			53
54	Radiology-Diagnostic	16,807	1,558		79,451			54
56	Radioisotope		125		37,045			56
56.01	ULTRASOUND		156		20,960			56.01
57	CT Scan		7,996		72,627			57
58	MRI		208					58
59	Cardiac Catheterization	130	1,422		84,326			59
60	Laboratory		126,048		245,178			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,024		90,662			65
66	Physical Therapy	13,419	302		31,683			66
67	Occupational Therapy		4		11,698			67
68	Speech Pathology		67		5,362			68
69	Electrocardiology	1,173	125		61,904			69
70	Electroencephalography		189		3,412			70
71	Medical Supplies Charged to Patients		734,026		125,757			71
72	Impl. Dev. Charged to Patients		675,291					72
73	Drugs Charged to Patients		118,425	5,416,403	491,817			73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	11,205	122		1,462			76.01
76.02	GASTRO INTESTINAL SERVICES	67,879	5,143					76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic				975			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	36,089	1,423					90.02
90.03	RIVER FOREST							90.03
91	Emergency	266,043	5,737		135,018	22,173	371,923	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	651	179					101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	130	18					116
118	SUBTOTALS (sum of lines 1-117)	3,050,377	2,046,780	5,416,403	2,808,578	397,281	375,680	118

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	
		13	14	15	16	17	22	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1					190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY		35,518	1,552,780				192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers		36					193
193.01	ADULT DAY CARE	14,201	98					193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,064,578	2,082,433	6,969,183	2,808,578	397,281	375,680	202

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	20,806,467	-3,757	20,802,710				30
31	Intensive Care Unit	5,238,534		5,238,534				31
40	Subprovider - IPF	2,109,862		2,109,862				40
43	Nursery	1,091,351		1,091,351				43
44	Skilled Nursing Facility	6,195,014		6,195,014				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	10,672,076		10,672,076				50
51	Recovery Room	1,016,508		1,016,508				51
52	Delivery Room & Labor Room	3,009,242		3,009,242				52
53	Anesthesiology	162,086		162,086				53
54	Radiology-Diagnostic	3,093,180		3,093,180				54
56	Radioisotope	467,101		467,101				56
56.01	ULTRASOUND	976,576		976,576				56.01
57	CT Scan	920,112		920,112				57
58	MRI	430,391		430,391				58
59	Cardiac Catheterization	1,286,591		1,286,591				59
60	Laboratory	6,939,187		6,939,187				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,763,916		1,763,916				65
66	Physical Therapy	2,444,543		2,444,543				66
67	Occupational Therapy	490,238		490,238				67
68	Speech Pathology	413,352		413,352				68
69	Electrocardiology	943,194		943,194				69
70	Electroencephalography	195,605		195,605				70
71	Medical Supplies Charged to Patients	7,679,373		7,679,373				71
72	Impl. Dev. Charged to Patients	6,949,256		6,949,256				72
73	Drugs Charged to Patients	7,126,903		7,126,903				73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis	334,808		334,808				74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	575,810		575,810				76.01
76.02	GASTRO INTESTINAL SERVICES	1,534,676		1,534,676				76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	5,586		5,586				90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	995,419		995,419				90.02
90.03	RIVER FOREST							90.03
91	Emergency	6,175,362	-371,923	5,803,439				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	493,890		493,890				101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	13,769		13,769				116
118	SUBTOTALS (sum of lines 1-117)	102,549,978	-375,680	102,174,298				118

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	175,777		175,777				190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	3,730,191		3,730,191				192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	106,395		106,395				193
193.01	ADULT DAY CARE	344,429		344,429				193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	106,906,770	-375,680	106,531,090				202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		10,661	19,320	29,981	29,981		4
5	Administrative & General		436,866	396,055	832,921	2,506	835,427	5
6	Maintenance & Repairs		26,420	124,620	151,040	475	30,916	6
7	Operation of Plant		1,526,336	151,255	1,677,591	747	51,958	7
8	Laundry & Linen Service		25,363		25,363		6,378	8
9	Housekeeping		23,602	6,107	29,709	730	26,218	9
10	Dietary		135,882	2,927	138,809	191	8,172	10
11	Cafeteria		119,826	17,667	137,493	410	13,267	11
12	Maintenance of Personnel							12
13	Nursing Administration		38,397	121,660	160,057	1,145	22,863	13
14	Central Services & Supply		148,415	113,560	261,975	408	13,344	14
15	Pharmacy		50,856	185,752	236,608	1,345	43,424	15
16	Medical Records & Library		56,140		56,140	822	19,946	16
17	Social Service		30,239		30,239	129	2,624	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd						2,934	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,120,764	173,136	1,293,900	5,564	106,058	30
31	Intensive Care Unit		203,944	148,551	352,495	1,628	31,673	31
40	Subprovider - IPF		93,017	1,391	94,408	588	10,772	40
43	Nursery		23,991		23,991	364	6,534	43
44	Skilled Nursing Facility		222,818	7,058	229,876	1,339	35,944	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		471,463	1,055,486	1,526,949	1,901	55,456	50
51	Recovery Room		28,126	97,908	126,034	254	6,552	51
52	Delivery Room & Labor Room		129,226	71,812	201,038	998	18,853	52
53	Anesthesiology		8,658	14,720	23,378		698	53
54	Radiology-Diagnostic		186,182	220,999	407,181	933	19,328	54
56	Radioisotope		35,264		35,264	126	2,439	56
56.01	ULTRASOUND		35,486	117,396	152,882	338	6,766	56.01
57	CT Scan		22,582	17,896	40,478	282	5,641	57
58	MRI		43,551	4,337	47,888	123	2,738	58
59	Cardiac Catheterization		38,249	4,601	42,850	376	8,731	59
60	Laboratory		182,029	44,951	226,980	1,437	46,369	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		20,265	27,638	47,903	658	12,144	65
66	Physical Therapy		152,031	1,081	153,112	794	14,547	66
67	Occupational Therapy		30,684		30,684	160	2,918	67
68	Speech Pathology		19,671	1,653	21,324	130	2,621	68
69	Electrocardiology		38,156	19,695	57,851	260	4,844	69
70	Electroencephalography		19,338		19,338	59	1,167	70
71	Medical Supplies Charged to Patients						53,291	71
72	Impl. Dev. Charged to Patients						49,028	72
73	Drugs Charged to Patients						8,598	73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis						2,616	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION		66,912	1,117	68,029	139	2,912	76.01
76.02	GASTRO INTESTINAL SERVICES					466	10,212	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		1,706		1,706		15	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE		38,156	1,298	39,454	212	6,870	90.02
90.03	RIVER FOREST							90.03
91	Emergency		250,424	104,893	355,317	1,617	36,329	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		81,188		81,188		895	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice					1	18	116
118	SUBTOTALS (sum of lines 1-117)		6,192,884	3,276,540	9,469,424	29,655	815,621	118

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		22,601		22,601	17	1,061	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY		36,821	33	36,854	206	16,147	192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers		28,589		28,589		472	193
193.01	ADULT DAY CARE		29,294		29,294	103	2,126	193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		6,310,189	3,276,573	9,586,762	29,981	835,427	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs	182,431						6
7	Operation of Plant	12,833	1,743,129					7
8	Laundry & Linen Service		10,258	41,999				8
9	Housekeeping	86,126	9,546	3,594	155,923			9
10	Dietary	270	54,957	201	4,211	206,811		10
11	Cafeteria	431	48,463	322	3,689		204,075	11
12	Maintenance of Personnel							12
13	Nursing Administration		15,530		323		6,643	13
14	Central Services & Supply		60,026		2,369		5,543	14
15	Pharmacy	42,653	20,569		1,877		8,801	15
16	Medical Records & Library		22,706		1,097		9,868	16
17	Social Service		12,230				1,285	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		453,292		61,168	120,671	47,161	30
31	Intensive Care Unit		82,484		6,568	12,401	9,616	31
40	Subprovider - IPF		37,620			16,288	5,770	40
43	Nursery		9,703		1,437	8,023	2,401	43
44	Skilled Nursing Facility		90,118		13,137	49,428	12,973	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	29,113	190,682	37,546	15,412		14,373	50
51	Recovery Room		11,375		1,490		1,697	51
52	Delivery Room & Labor Room		52,265		3,009		6,618	52
53	Anesthesiology		3,502		217			53
54	Radiology-Diagnostic		75,301		3,912		8,925	54
56	Radioisotope		14,262		1,554		795	56
56.01	ULTRASOUND		14,352		323		2,166	56.01
57	CT Scan		9,133	30	1,718		2,199	57
58	MRI		17,614	78			828	58
59	Cardiac Catheterization		15,470				2,207	59
60	Laboratory		73,621		5,753		14,546	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		8,196		768		5,552	65
66	Physical Therapy		61,488		6,574		6,861	66
67	Occupational Therapy		12,410		1,325		1,046	67
68	Speech Pathology		7,956		850		1,186	68
69	Electrocardiology	5,383	15,432		1,666		2,520	69
70	Electroencephalography		7,821		170		577	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION		27,062		2,158		906	76.01
76.02	GASTRO INTESTINAL SERVICES	5,622					3,299	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		690					90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE		15,432				1,750	90.02
90.03	RIVER FOREST							90.03
91	Emergency		101,283	228	5,583		12,792	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		32,836		7,237		49	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice				328		4	116
118	SUBTOTALS (sum of lines 1-117)	182,431	1,695,685	41,999	155,923	206,811	200,957	118

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		9,141				375	190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY		14,892				1,643	192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers		11,563					193
193.01	ADULT DAY CARE		11,848				1,100	193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	182,431	1,743,129	41,999	155,923	206,811	204,075	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	
		13	14	15	16	17	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	206,561						13
14	Central Services & Supply		343,665					14
15	Pharmacy		41,883	397,160				15
16	Medical Records & Library	1,985	118		112,682			16
17	Social Service		19			46,526		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		39				2,973	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	89,650	1,631		17,992	29,546		30
31	Intensive Care Unit	20,444	544		4,791	3,051		31
40	Subprovider - IPF	9,695	165		6,864	11,332		40
43	Nursery	4,698	299		684			43
44	Skilled Nursing Facility	21,348	479					44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,718	13,465		18,050			50
51	Recovery Room	2,845	51		900			51
52	Delivery Room & Labor Room	12,347	314		1,408			52
53	Anesthesiology		930		1,838			53
54	Radiology-Diagnostic	1,133	257		3,188			54
56	Radioisotope		21		1,486			56
56.01	ULTRASOUND		26		841			56.01
57	CT Scan		1,319		2,914			57
58	MRI		34					58
59	Cardiac Catheterization	9	235		3,383			59
60	Laboratory		20,802		9,837			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		829		3,637			65
66	Physical Therapy	905	50		1,271			66
67	Occupational Therapy		1		469			67
68	Speech Pathology		11		215			68
69	Electrocardiology	79	21		2,484			69
70	Electroencephalography		31		137			70
71	Medical Supplies Charged to Patients		121,139		5,045			71
72	Impl. Dev. Charged to Patients		111,442					72
73	Drugs Charged to Patients		19,543	308,670	19,733			73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	755	20		59			76.01
76.02	GASTRO INTESTINAL SERVICES	4,575	849					76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic				39			90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	2,433	235					90.02
90.03	RIVER FOREST							90.03
91	Emergency	17,932	947		5,417	2,597		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	44	30					101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	9	3					116
118	SUBTOTALS (sum of lines 1-117)	205,604	337,782	308,670	112,682	46,526		118

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R PROGRAM COSTS	
		13	14	15	16	17	22	
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY		5,861	88,490				192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers		6					193
193.01	ADULT DAY CARE	957	16					193.01
200	Cross Foot Adjustments						2,973	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	206,561	343,665	397,160	112,682	46,526	2,973	202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,226,633		2,226,633				30
31	Intensive Care Unit	525,695		525,695				31
40	Subprovider - IPF	193,502		193,502				40
43	Nursery	58,134		58,134				43
44	Skilled Nursing Facility	454,642		454,642				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,917,665		1,917,665				50
51	Recovery Room	151,198		151,198				51
52	Delivery Room & Labor Room	296,850		296,850				52
53	Anesthesiology	30,563		30,563				53
54	Radiology-Diagnostic	520,158		520,158				54
56	Radioisotope	55,947		55,947				56
56.01	ULTRASOUND	177,694		177,694				56.01
57	CT Scan	63,714		63,714				57
58	MRI	69,303		69,303				58
59	Cardiac Catheterization	73,261		73,261				59
60	Laboratory	399,345		399,345				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	79,687		79,687				65
66	Physical Therapy	245,602		245,602				66
67	Occupational Therapy	49,013		49,013				67
68	Speech Pathology	34,293		34,293				68
69	Electrocardiology	90,540		90,540				69
70	Electroencephalography	29,300		29,300				70
71	Medical Supplies Charged to Patients	179,475		179,475				71
72	Impl. Dev. Charged to Patients	160,470		160,470				72
73	Drugs Charged to Patients	356,544		356,544				73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis	2,616		2,616				74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	102,040		102,040				76.01
76.02	GASTRO INTESTINAL SERVICES	25,023		25,023				76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,450		2,450				90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	66,386		66,386				90.02
90.03	RIVER FOREST							90.03
91	Emergency	540,042		540,042				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	122,279		122,279				101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	363		363				116
118	SUBTOTALS (sum of lines 1-117)	9,300,427		9,300,427				118

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	33,195		33,195				190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	164,093		164,093				192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	40,630		40,630				193
193.01	ADULT DAY CARE	45,444		45,444				193.01
200	Cross Foot Adjustments	2,973		2,973				200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,586,762		9,586,762				202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VAL UE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS MAINT REQS	
		1	2	4	5A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	340,349						1
2	Cap Rel Costs-Mvble Equip		15,595,822					2
4	Employee Benefits Department	575	91,961	46,852,376				4
5	Administrative & General	23,563	1,885,143	3,915,227	-9,299,796	97,606,974		5
6	Maintenance & Repairs	1,425	593,168	742,867		3,612,099	35,141	6
7	Operation of Plant	82,325	719,943	1,167,608		6,070,567	2,472	7
8	Laundry & Linen Service	1,368				745,160		8
9	Housekeeping	1,273	29,069	1,141,255		3,063,168	16,590	9
10	Dietary	7,329	13,931	298,737		954,816	52	10
11	Cafeteria	6,463	84,091	640,922		1,550,040	83	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,071	579,076	1,788,864		2,671,167		13
14	Central Services & Supply	8,005	540,522	637,852		1,559,080		14
15	Pharmacy	2,743	884,143	2,100,955		5,073,437	8,216	15
16	Medical Records & Library	3,028		1,284,248		2,330,360		16
17	Social Service	1,631		201,189		306,560		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					342,786		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	60,450	824,090	8,697,359		12,390,392		30
31	Intensive Care Unit	11,000	707,072	2,544,337		3,700,572		31
40	Subprovider - IPF	5,017	6,623	918,859		1,258,591		40
43	Nursery	1,294		568,101		763,400		43
44	Skilled Nursing Facility	12,018	33,593	2,092,149		4,199,572		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,429	5,023,904	2,969,653		6,479,304	5,608	50
51	Recovery Room	1,517	466,023	396,640		765,560		51
52	Delivery Room & Labor Room	6,970	341,812	1,560,100		2,202,660		52
53	Anesthesiology	467	70,062			81,524		53
54	Radiology-Diagnostic	10,042	1,051,909	1,457,895		2,258,255		54
56	Radioisotope	1,902		197,591		285,014		56
56.01	ULTRASOUND	1,914	558,779	527,457		790,497		56.01
57	CT Scan	1,218	85,179	440,886		659,094		57
58	MRI	2,349	20,644	192,899		319,871		58
59	Cardiac Catheterization	2,063	21,901	588,154		1,020,062		59
60	Laboratory	9,818	213,956	2,245,770		5,417,534		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093	131,549	1,028,890		1,418,897		65
66	Physical Therapy	8,200	5,143	1,239,865		1,699,612		66
67	Occupational Therapy	1,655		249,426		340,972		67
68	Speech Pathology	1,061	7,870	203,205		306,225		68
69	Electrocardiology	2,058	93,746	406,529		565,917	1,037	69
70	Electroencephalography	1,043		91,594		136,370		70
71	Medical Supplies Charged to Patients					6,226,355		71
72	Impl. Dev. Charged to Patients					5,728,194		72
73	Drugs Charged to Patients					1,004,547		73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis					305,683		74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609	5,318	217,230		340,206		76.01
76.02	GASTRO INTESTINAL SERVICES			728,595		1,193,188	1,083	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	92				1,706		90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	2,058	6,176	331,223		802,670		90.02
90.03	RIVER FOREST							90.03
91	Emergency	13,507	499,269	2,526,625		4,244,521		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	4,379				104,542		101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice			1,280		2,141		116

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VAL UE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS MAINT REQS	
		1	2	4	5A	5	6	
118	SUBTOTALS (sum of lines 1-117)	334,022	15,595,665	46,342,036	-9,299,796	95,292,888	35,141	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,219		27,235		123,912		190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	1,986	157	322,054		1,886,595		192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	1,542				55,153		193
193.01	ADULT DAY CARE	1,580		161,051		248,426		193.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	6,310,189	3,276,573	11,426,384		9,299,796	3,956,253	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.540348	0.210093	0.243881		0.095278	112.582254	203
204	Cost to be allocated (Per Wkst. B, Part II)			29,981		835,427	182,431	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000640		0.008559	5.191400	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY)	HOUSE-KEEPING HOURS OF S ERVICE)	DIETARY MEALS SERV ED)	CAFETERIA FTES SERVE D)	NURSING ADMINIS-TRATION FTES SERVE D)	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	232,461						7
8	Laundry & Linen Service	1,368	147,461					8
9	Housekeeping	1,273	12,619	26,587				9
10	Dietary	7,329	706	718	120,024			10
11	Cafeteria	6,463	1,132	629		49,552		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,071		55		1,613	23,522	13
14	Central Services & Supply	8,005		404		1,346		14
15	Pharmacy	2,743		320		2,137		15
16	Medical Records & Library	3,028		187		2,396	226	16
17	Social Service	1,631				312		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	60,450		10,430	70,032	11,451	10,209	30
31	Intensive Care Unit	11,000		1,120	7,197	2,335	2,328	31
40	Subprovider - IPF	5,017			9,453	1,401	1,104	40
43	Nursery	1,294		245	4,656	583	535	43
44	Skilled Nursing Facility	12,018		2,240	28,686	3,150	2,431	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,429	131,825	2,628		3,490	1,676	50
51	Recovery Room	1,517		254		412	324	51
52	Delivery Room & Labor Room	6,970		513		1,607	1,406	52
53	Anesthesiology	467		37				53
54	Radiology-Diagnostic	10,042		667		2,167	129	54
56	Radioisotope	1,902		265		193		56
56.01	ULTRASOUND	1,914		55		526		56.01
57	CT Scan	1,218	106	293		534		57
58	MRI	2,349	274			201		58
59	Cardiac Catheterization	2,063				536	1	59
60	Laboratory	9,818		981		3,532		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093		131		1,348		65
66	Physical Therapy	8,200		1,121		1,666	103	66
67	Occupational Therapy	1,655		226		254		67
68	Speech Pathology	1,061		145		288		68
69	Electrocardiology	2,058		284		612	9	69
70	Electroencephalography	1,043		29		140		70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	3,609		368		220	86	76.01
76.02	GASTRO INTESTINAL SERVICES					801	521	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	92						90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	2,058				425	277	90.02
90.03	RIVER FOREST							90.03
91	Emergency	13,507	799	952		3,106	2,042	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	4,379		1,234		12	5	101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice			56		1	1	116

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY)	HOUSE-KEEPING HOURS OF S ERVICE)	DIETARY MEALS SERV ED)	CAFETERIA FTES SERVE D)	NURSING ADMINIS-TRATION FTES SERVE D)	
		7	8	9	10	11	13	
118	SUBTOTALS (sum of lines 1-117)	226,134	147,461	26,587	120,024	48,795	23,413	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,219				91		190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	1,986				399		192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	1,542						193
193.01	ADULT DAY CARE	1,580				267	109	193.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	6,927,261	856,923	5,334,027	1,418,197	2,032,435	3,064,578	202
203	Unit Cost Multiplier (Wkst. B, Part I)	29.799670	5.811184	200.625381	11.815945	41.016205	130.285605	203
204	Cost to be allocated (Per Wkst. B, Part II)	1,743,129	41,999	155,923	206,811	204,075	206,561	204
205	Unit Cost Multiplier (Wkst. B, Part II)	7.498587	0.284814	5.864633	1.723080	4.118401	8.781609	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS)	PHARMACY COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	SOCIAL SERVICE TIME SPENT)	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	17,664,287						14
15	Pharmacy	2,152,794	1,049,798					15
16	Medical Records & Library	6,071		5,762				16
17	Social Service	961			8,708			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					100		21
22	I&R Services-Other Prgm Costs Apprvd	1,982					100	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	83,855		920	5,530	1	1	30
31	Intensive Care Unit	27,952		245	571			31
40	Subprovider - IPF	8,496		351	2,121			40
43	Nursery	15,370		35				43
44	Skilled Nursing Facility	24,640						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	692,096		923				50
51	Recovery Room	2,615		46				51
52	Delivery Room & Labor Room	16,136		72				52
53	Anesthesiology	47,814		94				53
54	Radiology-Diagnostic	13,216		163				54
56	Radioisotope	1,062		76				56
56.01	ULTRASOUND	1,325		43				56.01
57	CT Scan	67,823		149				57
58	MRI	1,766						58
59	Cardiac Catheterization	12,061		173				59
60	Laboratory	1,069,212		503				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	42,620		186				65
66	Physical Therapy	2,564		65				66
67	Occupational Therapy	33		24				67
68	Speech Pathology	572		11				68
69	Electrocardiology	1,063		127				69
70	Electroencephalography	1,605		7				70
71	Medical Supplies Charged to Patients	6,226,353		258				71
72	Impl. Dev. Charged to Patients	5,728,193						72
73	Drugs Charged to Patients	1,004,547	815,896	1,009				73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	1,031		3				76.01
76.02	GASTRO INTESTINAL SERVICES	43,627						76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic			2				90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	12,067						90.02
90.03	RIVER FOREST							90.03
91	Emergency	48,668		277	486	99	99	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency	1,522						101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice	149						116

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS)	PHARMACY COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	SOCIAL SERVICE TIME SPENT)	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)	
		14	15	16	17	21	22	
118	SUBTOTALS (sum of lines 1-117)	17,361,861	815,896	5,762	8,708	100	100	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8						190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY	301,280	233,902					192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers	308						193
193.01	ADULT DAY CARE	830						193.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,082,433	6,969,183	2,808,578	397,281		375,680	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.117889	6.638594	487.431100	45.622531		3,756.800000	203
204	Cost to be allocated (Per Wkst. B, Part II)	343,665	397,160	112,682	46,526		2,973	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.019455	0.378320	19.556057	5.342903		29.730000	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
44	Skilled Nursing Facility							44
	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency							101

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY							192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers							193
193.01	ADULT DAY CARE							193.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	20,802,710		20,802,710		20,802,710	30
31	Intensive Care Unit	5,238,534		5,238,534		5,238,534	31
40	Subprovider - IPF	2,109,862		2,109,862		2,109,862	40
43	Nursery	1,091,351		1,091,351		1,091,351	43
44	Skilled Nursing Facility	6,195,014		6,195,014		6,195,014	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	10,672,076		10,672,076		10,672,076	50
51	Recovery Room	1,016,508		1,016,508		1,016,508	51
52	Delivery Room & Labor Room	3,009,242		3,009,242		3,009,242	52
53	Anesthesiology	162,086		162,086		162,086	53
54	Radiology-Diagnostic	3,093,180		3,093,180		3,093,180	54
56	Radioisotope	467,101		467,101		467,101	56
56.01	ULTRASOUND	976,576		976,576		976,576	56.01
57	CT Scan	920,112		920,112		920,112	57
58	MRI	430,391		430,391		430,391	58
59	Cardiac Catheterization	1,286,591		1,286,591		1,286,591	59
60	Laboratory	6,939,187		6,939,187		6,939,187	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,763,916		1,763,916		1,763,916	65
66	Physical Therapy	2,444,543		2,444,543		2,444,543	66
67	Occupational Therapy	490,238		490,238		490,238	67
68	Speech Pathology	413,352		413,352		413,352	68
69	Electrocardiology	943,194		943,194		943,194	69
70	Electroencephalography	195,605		195,605		195,605	70
71	Medical Supplies Charged to Patients	7,679,373		7,679,373		7,679,373	71
72	Impl. Dev. Charged to Patients	6,949,256		6,949,256		6,949,256	72
73	Drugs Charged to Patients	7,126,903		7,126,903		7,126,903	73
73.01	OUTPATIENT PHARMACY						73.01
74	Renal Dialysis	334,808		334,808		334,808	74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	575,810		575,810		575,810	76.01
76.02	GASTRO INTESTINAL SERVICES	1,534,676		1,534,676		1,534,676	76.02
76.05	INPATIENT RENAL DIALYSIS						76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	5,586		5,586		5,586	90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	995,419		995,419		995,419	90.02
90.03	RIVER FOREST						90.03
91	Emergency	5,803,439		5,803,439		5,803,439	91
92	Observation Beds (Non-Distinct Part)	2,283,581		2,283,581		2,283,581	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
101	Home Health Agency	493,890		493,890		493,890	101
116	Hospice	13,769		13,769		13,769	116
200	Subtotal (sum of lines 30 thru 199)	104,457,879		104,457,879		104,457,879	200
201	Less Observation Beds	2,283,581		2,283,581		2,283,581	201
202	Total (line 200 minus line 201)	102,174,298		102,174,298		102,174,298	202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

	COST CENTER DESCRIPTIONS	CHARGES Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	57,072,376		57,072,376				30
31	Intensive Care Unit	11,121,890		11,121,890				31
40	Subprovider - IPF	6,795,360		6,795,360				40
43	Nursery	2,631,365		2,631,365				43
44	Skilled Nursing Facility	7,240,602		7,240,602				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,408,734	13,391,950	21,800,684	0.489529	0.489529	0.489529	50
51	Recovery Room	3,593,552	4,995,791	8,589,343	0.118345	0.118345	0.118345	51
52	Delivery Room & Labor Room	5,275,877	228,811	5,504,688	0.546669	0.546669	0.546669	52
53	Anesthesiology	7,953,533	12,021,315	19,974,848	0.008115	0.008115	0.008115	53
54	Radiology-Diagnostic	4,749,439	14,625,091	19,374,530	0.159652	0.159652	0.159652	54
56	Radioisotope	1,633,221	4,784,922	6,418,143	0.072778	0.072778	0.072778	56
56.01	ULTRASOUND	2,802,679	8,116,870	10,919,549	0.089434	0.089434	0.089434	56.01
57	CT Scan	14,122,162	29,310,937	43,433,099	0.021185	0.021185	0.021185	57
58	MRI	2,607,456	11,415,594	14,023,050	0.030692	0.030692	0.030692	58
59	Cardiac Catheterization	6,140,497	5,559,964	11,700,461	0.109961	0.109961	0.109961	59
60	Laboratory	30,467,357	51,473,440	81,940,797	0.084685	0.084685	0.084685	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,280,369	785,946	9,066,315	0.194557	0.194557	0.194557	65
66	Physical Therapy	8,432,882	4,833,958	13,266,840	0.184260	0.184260	0.184260	66
67	Occupational Therapy	4,263,148	676,143	4,939,291	0.099253	0.099253	0.099253	67
68	Speech Pathology	1,263,258	722,484	1,985,742	0.208160	0.208160	0.208160	68
69	Electrocardiology	8,247,402	9,674,383	17,921,785	0.052628	0.052628	0.052628	69
70	Electroencephalography	279,595	1,671,334	1,950,929	0.100262	0.100262	0.100262	70
71	Medical Supplies Charged to Patients	5,225,534	3,963,213	9,188,747	0.835737	0.835737	0.835737	71
72	Impl. Dev. Charged to Patients	10,407,121	3,889,349	14,296,470	0.486082	0.486082	0.486082	72
73	Drugs Charged to Patients	17,427,723	9,432,206	26,859,929	0.265336	0.265336	0.265336	73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis	1,105,421	17,831	1,123,252	0.298070	0.298070	0.298070	74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION	528	906,040	906,568	0.635154	0.635154	0.635154	76.01
76.02	GASTRO INTESTINAL SERVICES	2,328,382	9,787,948	12,116,330	0.126662	0.126662	0.126662	76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		25,088	25,088	0.222656	0.222656	0.222656	90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE	6,116	2,702,245	2,708,361	0.367536	0.367536	0.367536	90.02
90.03	RIVER FOREST							90.03
91	Emergency	15,525,094	34,007,160	49,532,254	0.117165	0.117165	0.117165	91
92	Observation Beds (Non-Distinct Part)	3,162,033	6,130,176	9,292,209	0.245752	0.245752	0.245752	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency		10,952	10,952				101
116	Hospice		48,369	48,369				116
200	Subtotal (sum of lines 30 thru 199)	258,570,706	245,209,510	503,780,216				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	258,570,706	245,209,510	503,780,216				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

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Check        [  ] Title V                  [XX] PPS
Applicable   [XX] Title XVIII, Part A      [  ] TEFRA
Boxes:       [  ] Title XIX
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		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,226,633		2,226,633	25,817	86.25	10,821	933,311	30
31	Intensive Care Unit	525,695		525,695	2,362	222.56	1,007	224,118	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	193,502		193,502	3,155	61.33	2,985	183,070	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	58,134		58,134	1,528	38.05			43
44	Skilled Nursing Facility	454,642		454,642	9,562	47.55	7,206	342,645	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,458,606		3,458,606	42,424		22,019	1,683,144	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART II**

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Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,917,665	21,800,684	0.087964	3,234,516	284,521	50
51	Recovery Room	151,198	8,589,343	0.017603	1,377,289	24,244	51
52	Delivery Room & Labor Room	296,850	5,504,688	0.053927	16,368	883	52
53	Anesthesiology	30,563	19,974,848	0.001530	2,940,497	4,499	53
54	Radiology-Diagnostic	520,158	19,374,530	0.026848	2,253,353	60,498	54
56	Radioisotope	55,947	6,418,143	0.008717	727,325	6,340	56
56.01	ULTRASOUND	177,694	10,919,549	0.016273	1,220,201	19,856	56.01
57	CT Scan	63,714	43,433,099	0.001467	6,044,038	8,867	57
58	MRI	69,303	14,023,050	0.004942	1,212,847	5,994	58
59	Cardiac Catheterization	73,261	11,700,461	0.006261	2,346,770	14,693	59
60	Laboratory	399,345	81,940,797	0.004874	12,781,396	62,297	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	79,687	9,066,315	0.008789	3,267,787	28,721	65
66	Physical Therapy	245,602	13,266,840	0.018512	2,195,990	40,652	66
67	Occupational Therapy	49,013	4,939,291	0.009923	777,244	7,713	67
68	Speech Pathology	34,293	1,985,742	0.017270	166,772	2,880	68
69	Electrocardiology	90,540	17,921,785	0.005052	4,120,476	20,817	69
70	Electroencephalography	29,300	1,950,929	0.015018	148,552	2,231	70
71	Medical Supplies Charged to Pat	179,475	9,188,747	0.019532	2,225,718	43,473	71
72	Impl. Dev. Charged to Patients	160,470	14,296,470	0.011224	4,734,610	53,141	72
73	Drugs Charged to Patients	356,544	26,859,929	0.013274	6,500,056	86,282	73
73.01	OUTPATIENT PHARMACY						73.01
74	Renal Dialysis	2,616	1,123,252	0.002329	412,507	961	74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	102,040	906,568	0.112556	264	30	76.01
76.02	GASTRO INTESTINAL SERVICES	25,023	12,116,330	0.002065	1,167,818	2,412	76.02
76.05	INPATIENT RENAL DIALYSIS						76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,450	25,088	0.097656			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	66,386	2,708,361	0.024512	4,206	103	90.02
90.03	RIVER FOREST						90.03
91	Emergency	540,042	49,532,254	0.010903	6,618,792	72,165	91
92	Observation Beds (Non-Distinct	244,425	9,292,209	0.026304	1,351,098	35,539	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,963,604	418,859,302		67,846,490	889,812	200

(A) Worksheet A line numbers

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

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Check        [  ] Title V                  [XX] PPS
Applicable   [XX] Title XVIII, Part A      [  ] TEFRA
Boxes:       [  ] Title XIX                [  ] Other
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		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						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 (lines 30-199)						200

(A) Worksheet A line numbers

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

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Check        [  ] Title V                  [XX] PPS
Applicable   [XX] Title XVIII, Part A      [  ] TEFRA
Boxes:       [  ] Title XIX                [  ] Other
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		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	25,817		10,821		30
31	Intensive Care Unit	2,362		1,007		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	3,155		2,985		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,528				43
44	Skilled Nursing Facility	9,562		7,206		44
45	Nursing Facility					45
200	Total (lines 30-199)	42,424		22,019		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART IV**

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Check        [  ] Title V                 [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A     [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX               [  ] IRF          [  ] NF                                     [  ] Other
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		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF          [  ] NF                                     [  ] Other
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		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684			3,234,516		3,210,687		50
51	Recovery Room	8,589,343			1,377,289		841,971		51
52	Delivery Room & Labor Room	5,504,688			16,368		501		52
53	Anesthesiology	19,974,848			2,940,497		3,039,348		53
54	Radiology-Diagnostic	19,374,530			2,253,353		2,472,934		54
56	Radioisotope	6,418,143			727,325		1,723,429		56
56.01	ULTRASOUND	10,919,549			1,220,201		1,705,917		56.01
57	CT Scan	43,433,099			6,044,038		8,358,809		57
58	MRI	14,023,050			1,212,847		3,118,609		58
59	Cardiac Catheterization	11,700,461			2,346,770		2,904,431		59
60	Laboratory	81,940,797			12,781,396		4,048,103		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315			3,267,787		256,196		65
66	Physical Therapy	13,266,840			2,195,990		38,965		66
67	Occupational Therapy	4,939,291			777,244		6,914		67
68	Speech Pathology	1,985,742			166,772		93,275		68
69	Electrocardiology	17,921,785			4,120,476		2,916,745		69
70	Electroencephalography	1,950,929			148,552		332,539		70
71	Medical Supplies Charged to Pat	9,188,747			2,225,718		976,825		71
72	Impl. Dev. Charged to Patients	14,296,470			4,734,610		1,017,100		72
73	Drugs Charged to Patients	26,859,929			6,500,056		2,641,558		73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252			412,507		28,661		74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568			264		432,561		76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330			1,167,818		2,565,566		76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361			4,206		1,052,611		90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254			6,618,792		4,994,261		91
92	Observation Beds (Non-Distinct	9,292,209			1,351,098		1,695,308		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302			67,846,490		50,473,824		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART V**

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Check        [ ] Title V - O/P          [XX] Hospital     [ ] SUB (Other)          [ ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B   [ ] IPF           [ ] SNF                  [ ] Swing Bed NF
Boxes:       [ ] Title XIX - O/P        [ ] IRF           [ ] NF                   [ ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529	3,210,687			1,571,724			50
51	Recovery Room	0.118345	841,971			99,643			51
52	Delivery Room & Labor Room	0.546669	501			274			52
53	Anesthesiology	0.008115	3,039,348			24,664			53
54	Radiology-Diagnostic	0.159652	2,472,934			394,809			54
56	Radioisotope	0.072778	1,723,429			125,428			56
56.01	ULTRASOUND	0.089434	1,705,917			152,567			56.01
57	CT Scan	0.021185	8,358,809			177,081			57
58	MRI	0.030692	3,118,609			95,716			58
59	Cardiac Catheterization	0.109961	2,904,431			319,374			59
60	Laboratory	0.084685	4,048,103			342,814			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557	256,196			49,845			65
66	Physical Therapy	0.184260	38,965			7,180			66
67	Occupational Therapy	0.099253	6,914			686			67
68	Speech Pathology	0.208160	93,275			19,416			68
69	Electrocardiology	0.052628	2,916,745			153,502			69
70	Electroencephalography	0.100262	332,539			33,341			70
71	Medical Supplies Charged to Pat	0.835737	976,825	15,373		816,369	12,848		71
72	Impl. Dev. Charged to Patients	0.486082	1,017,100			494,394			72
73	Drugs Charged to Patients	0.265336	2,641,558		21,710	700,900		5,760	73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070	28,661			8,543			74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154	432,561			274,743			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662	2,565,566			324,960			76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536	1,052,611			386,872			90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165	4,994,261			585,153			91
92	Observation Beds (Non-Distinct	0.245752	1,695,308			416,625			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		50,473,824	15,373	21,710	7,576,623	12,848	5,760	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		50,473,824	15,373	21,710	7,576,623	12,848	5,760	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART II**

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Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [XX] Title XVIII, Part A    [XX] IPF                                    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,917,665	21,800,684	0.087964			50
51	Recovery Room	151,198	8,589,343	0.017603			51
52	Delivery Room & Labor Room	296,850	5,504,688	0.053927	10	1	52
53	Anesthesiology	30,563	19,974,848	0.001530			53
54	Radiology-Diagnostic	520,158	19,374,530	0.026848	26,387	708	54
56	Radioisotope	55,947	6,418,143	0.008717			56
56.01	ULTRASOUND	177,694	10,919,549	0.016273	9,759	159	56.01
57	CT Scan	63,714	43,433,099	0.001467	58,766	86	57
58	MRI	69,303	14,023,050	0.004942	37,288	184	58
59	Cardiac Catheterization	73,261	11,700,461	0.006261	4,381	27	59
60	Laboratory	399,345	81,940,797	0.004874	462,557	2,255	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	79,687	9,066,315	0.008789	45,882	403	65
66	Physical Therapy	245,602	13,266,840	0.018512	139,896	2,590	66
67	Occupational Therapy	49,013	4,939,291	0.009923	24,986	248	67
68	Speech Pathology	34,293	1,985,742	0.017270	14,331	247	68
69	Electrocardiology	90,540	17,921,785	0.005052	12,496	63	69
70	Electroencephalography	29,300	1,950,929	0.015018	9,203	138	70
71	Medical Supplies Charged to Pat	179,475	9,188,747	0.019532	2,475	48	71
72	Impl. Dev. Charged to Patients	160,470	14,296,470	0.011224			72
73	Drugs Charged to Patients	356,544	26,859,929	0.013274	240,641	3,194	73
73.01	OUTPATIENT PHARMACY						73.01
74	Renal Dialysis	2,616	1,123,252	0.002329			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	102,040	906,568	0.112556			76.01
76.02	GASTRO INTESTINAL SERVICES	25,023	12,116,330	0.002065			76.02
76.05	INPATIENT RENAL DIALYSIS						76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,450	25,088	0.097656			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	66,386	2,708,361	0.024512			90.02
90.03	RIVER FOREST						90.03
91	Emergency	540,042	49,532,254	0.010903	112,095	1,222	91
92	Observation Beds (Non-Distinct		9,292,209				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,719,179	418,859,302		1,201,153	11,573	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [XX] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF          [  ] NF                                     [  ] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART IV**

```
Check        [ ] Title V                [ ] Hospital     [ ] SUB (Other)          [ ] ICF/IID     [XX] PPS
Applicable   [XX] Title XVIII, Part A   [XX] IPF          [ ] SNF                                  [ ] TEFRA
Boxes:       [ ] Title XIX              [ ] IRF          [ ] NF                                   [ ] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684							50
51	Recovery Room	8,589,343							51
52	Delivery Room & Labor Room	5,504,688			10				52
53	Anesthesiology	19,974,848							53
54	Radiology-Diagnostic	19,374,530			26,387				54
56	Radioisotope	6,418,143							56
56.01	ULTRASOUND	10,919,549			9,759				56.01
57	CT Scan	43,433,099			58,766				57
58	MRI	14,023,050			37,288				58
59	Cardiac Catheterization	11,700,461			4,381				59
60	Laboratory	81,940,797			462,557				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315			45,882				65
66	Physical Therapy	13,266,840			139,896				66
67	Occupational Therapy	4,939,291			24,986				67
68	Speech Pathology	1,985,742			14,331				68
69	Electrocardiology	17,921,785			12,496				69
70	Electroencephalography	1,950,929			9,203				70
71	Medical Supplies Charged to Pat	9,188,747			2,475				71
72	Impl. Dev. Charged to Patients	14,296,470							72
73	Drugs Charged to Patients	26,859,929			240,641				73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568							76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361							90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254			112,095				91
92	Observation Beds (Non-Distinct	9,292,209							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302			1,201,153				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART V**

Check Applicable Boxes:	**[ ] Title V - O/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**
	[XX] Title XVIII, Part B	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**
	[ ] Title XIX - O/P	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529							50
51	Recovery Room	0.118345							51
52	Delivery Room & Labor Room	0.546669							52
53	Anesthesiology	0.008115							53
54	Radiology-Diagnostic	0.159652							54
56	Radioisotope	0.072778							56
56.01	ULTRASOUND	0.089434							56.01
57	CT Scan	0.021185							57
58	MRI	0.030692							58
59	Cardiac Catheterization	0.109961							59
60	Laboratory	0.084685							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557							65
66	Physical Therapy	0.184260							66
67	Occupational Therapy	0.099253							67
68	Speech Pathology	0.208160							68
69	Electrocardiology	0.052628							69
70	Electroencephalography	0.100262							70
71	Medical Supplies Charged to Pat	0.835737							71
72	Impl. Dev. Charged to Patients	0.486082							72
73	Drugs Charged to Patients	0.265336							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154							76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165							91
92	Observation Beds (Non-Distinct	0.245752							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART IV**

```
Check        [  ] Title V                 [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A     [  ] IPF          [XX] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX               [  ] IRF          [  ] NF                                     [  ] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF          [XX] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX              [  ] IRF          [  ] NF                                     [  ] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684			20,296				50
51	Recovery Room	8,589,343			70				51
52	Delivery Room & Labor Room	5,504,688			45				52
53	Anesthesiology	19,974,848			37,850				53
54	Radiology-Diagnostic	19,374,530			135,305				54
56	Radioisotope	6,418,143			14,112				56
56.01	ULTRASOUND	10,919,549			119,670				56.01
57	CT Scan	43,433,099			160,877				57
58	MRI	14,023,050			36,273				58
59	Cardiac Catheterization	11,700,461			23,301				59
60	Laboratory	81,940,797			822,623				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315			517,732				65
66	Physical Therapy	13,266,840			3,236,635				66
67	Occupational Therapy	4,939,291			2,102,117				67
68	Speech Pathology	1,985,742			747,244				68
69	Electrocardiology	17,921,785			94,726				69
70	Electroencephalography	1,950,929			4,753				70
71	Medical Supplies Charged to Pat	9,188,747			291,965				71
72	Impl. Dev. Charged to Patients	14,296,470							72
73	Drugs Charged to Patients	26,859,929			971,428				73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568							76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361							90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254			8,920				91
92	Observation Beds (Non-Distinct	9,292,209							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302			9,345,942				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P        [  ] Hospital     [  ] SUB (Other)        [  ] Swing Bed SNF
Applicable   [XX] Title XVIII, Part B  [  ] IPF          [XX] SNF                [  ] Swing Bed NF
Boxes:       [  ] Title XIX - O/P      [  ] IRF          [  ] NF                 [  ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529							50
51	Recovery Room	0.118345							51
52	Delivery Room & Labor Room	0.546669							52
53	Anesthesiology	0.008115							53
54	Radiology-Diagnostic	0.159652							54
56	Radioisotope	0.072778							56
56.01	ULTRASOUND	0.089434							56.01
57	CT Scan	0.021185							57
58	MRI	0.030692							58
59	Cardiac Catheterization	0.109961							59
60	Laboratory	0.084685							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557							65
66	Physical Therapy	0.184260							66
67	Occupational Therapy	0.099253							67
68	Speech Pathology	0.208160							68
69	Electrocardiology	0.052628							69
70	Electroencephalography	0.100262							70
71	Medical Supplies Charged to Pat	0.835737							71
72	Impl. Dev. Charged to Patients	0.486082							72
73	Drugs Charged to Patients	0.265336							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154							76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165							91
92	Observation Beds (Non-Distinct	0.245752							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS **WORKSHEET D PART I**

```
Check        [  ] Title V
Applicable   [  ] Title XVIII, Part A
Boxes:       [XX] Title XIX
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		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	2,226,633		2,226,633	25,817	86.25	845	72,881	30
31	Intensive Care Unit	525,695		525,695	2,362	222.56	96	21,366	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	193,502		193,502	3,155	61.33	5	307	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	58,134		58,134	1,528	38.05	155	5,898	43
44	Skilled Nursing Facility	454,642		454,642	9,562	47.55	101	4,803	44
45	Nursing Facility								45
200	Total (lines 30-199)	3,458,606		3,458,606	42,424		1,202	105,255	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART II**

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)
Applicable   [  ] Title XVIII, Part A    [  ] IPF
Boxes:       [XX] Title XIX              [  ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,917,665	21,800,684	0.087964	485,830	42,736	50
51	Recovery Room	151,198	8,589,343	0.017603	189,784	3,341	51
52	Delivery Room & Labor Room	296,850	5,504,688	0.053927			52
53	Anesthesiology	30,563	19,974,848	0.001530	589,789	902	53
54	Radiology-Diagnostic	520,158	19,374,530	0.026848	297,139	7,978	54
56	Radioisotope	55,947	6,418,143	0.008717	81,870	714	56
56.01	ULTRASOUND	177,694	10,919,549	0.016273	193,763	3,153	56.01
57	CT Scan	63,714	43,433,099	0.001467	1,004,551	1,474	57
58	MRI	69,303	14,023,050	0.004942	114,161	564	58
59	Cardiac Catheterization	73,261	11,700,461	0.006261	234,099	1,466	59
60	Laboratory	399,345	81,940,797	0.004874	2,422,947	11,809	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	79,687	9,066,315	0.008789	680,737	5,983	65
66	Physical Therapy	245,602	13,266,840	0.018512	153,381	2,839	66
67	Occupational Therapy	49,013	4,939,291	0.009923	68,307	678	67
68	Speech Pathology	34,293	1,985,742	0.017270	9,285	160	68
69	Electrocardiology	90,540	17,921,785	0.005052	438,603	2,216	69
70	Electroencephalography	29,300	1,950,929	0.015018	15,495	233	70
71	Medical Supplies Charged to Pat	179,475	9,188,747	0.019532	221,237	4,321	71
72	Impl. Dev. Charged to Patients	160,470	14,296,470	0.011224	303,752	3,409	72
73	Drugs Charged to Patients	356,544	26,859,929	0.013274	1,134,846	15,064	73
73.01	OUTPATIENT PHARMACY						73.01
74	Renal Dialysis	2,616	1,123,252	0.002329			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	102,040	906,568	0.112556			76.01
76.02	GASTRO INTESTINAL SERVICES	25,023	12,116,330	0.002065	136,371	282	76.02
76.05	INPATIENT RENAL DIALYSIS						76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,450	25,088	0.097656			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	66,386	2,708,361	0.024512			90.02
90.03	RIVER FOREST						90.03
91	Emergency	540,042	49,532,254	0.010903	1,250,631	13,636	91
92	Observation Beds (Non-Distinct	244,425	9,292,209	0.026304	245,758	6,464	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,963,604	418,859,302		10,272,336	129,422	200

(A) Worksheet A line numbers

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

```
Check        [  ] Title V                  [  ] PPS
Applicable   [  ] Title XVIII, Part A      [  ] TEFRA
Boxes:       [XX] Title XIX                [XX] Other
```

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						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 (lines 30-199)						200

(A) Worksheet A line numbers

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

```
Check        [  ] Title V                  [  ] PPS
Applicable   [  ] Title XVIII, Part A      [  ] TEFRA
Boxes:       [XX] Title XIX                [XX] Other
```

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	25,817		845		30
31	Intensive Care Unit	2,362		96		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	3,155		5		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,528		155		43
44	Skilled Nursing Facility	9,562		101		44
45	Nursing Facility					45
200	Total (lines 30-199)	42,424		1,202		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                 [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A     [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX               [  ] IRF          [  ] NF                                     [XX] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF          [  ] NF                                     [XX] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684			485,830				50
51	Recovery Room	8,589,343			189,784				51
52	Delivery Room & Labor Room	5,504,688							52
53	Anesthesiology	19,974,848			589,789				53
54	Radiology-Diagnostic	19,374,530			297,139				54
56	Radioisotope	6,418,143			81,870				56
56.01	ULTRASOUND	10,919,549			193,763				56.01
57	CT Scan	43,433,099			1,004,551				57
58	MRI	14,023,050			114,161				58
59	Cardiac Catheterization	11,700,461			234,099				59
60	Laboratory	81,940,797			2,422,947				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315			680,737				65
66	Physical Therapy	13,266,840			153,381				66
67	Occupational Therapy	4,939,291			68,307				67
68	Speech Pathology	1,985,742			9,285				68
69	Electrocardiology	17,921,785			438,603				69
70	Electroencephalography	1,950,929			15,495				70
71	Medical Supplies Charged to Pat	9,188,747			221,237				71
72	Impl. Dev. Charged to Patients	14,296,470			303,752				72
73	Drugs Charged to Patients	26,859,929			1,134,846				73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568							76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330			136,371				76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361							90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254			1,250,631				91
92	Observation Beds (Non-Distinct	9,292,209			245,758				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302			10,272,336				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0008** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P          [XX] Hospital     [  ] SUB (Other)          [  ] Swing Bed SNF
Applicable   [  ] Title XVIII, Part B    [  ] IPF          [  ] SNF                  [  ] Swing Bed NF
Boxes:       [XX] Title XIX - O/P        [  ] IRF          [  ] NF                   [  ] ICF/IID
```

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529							50
51	Recovery Room	0.118345							51
52	Delivery Room & Labor Room	0.546669							52
53	Anesthesiology	0.008115							53
54	Radiology-Diagnostic	0.159652							54
56	Radioisotope	0.072778							56
56.01	ULTRASOUND	0.089434							56.01
57	CT Scan	0.021185							57
58	MRI	0.030692							58
59	Cardiac Catheterization	0.109961							59
60	Laboratory	0.084685							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557							65
66	Physical Therapy	0.184260							66
67	Occupational Therapy	0.099253							67
68	Speech Pathology	0.208160							68
69	Electrocardiology	0.052628							69
70	Electroencephalography	0.100262							70
71	Medical Supplies Charged to Pat	0.835737							71
72	Impl. Dev. Charged to Patients	0.486082							72
73	Drugs Charged to Patients	0.265336							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154							76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165							91
92	Observation Beds (Non-Distinct	0.245752							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART II**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)
Applicable   [  ] Title XVIII, Part A    [XX] IPF
Boxes:       [XX] Title XIX              [  ] IRF
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		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,917,665	21,800,684	0.087964			50
51	Recovery Room	151,198	8,589,343	0.017603			51
52	Delivery Room & Labor Room	296,850	5,504,688	0.053927			52
53	Anesthesiology	30,563	19,974,848	0.001530			53
54	Radiology-Diagnostic	520,158	19,374,530	0.026848			54
56	Radioisotope	55,947	6,418,143	0.008717			56
56.01	ULTRASOUND	177,694	10,919,549	0.016273			56.01
57	CT Scan	63,714	43,433,099	0.001467			57
58	MRI	69,303	14,023,050	0.004942			58
59	Cardiac Catheterization	73,261	11,700,461	0.006261			59
60	Laboratory	399,345	81,940,797	0.004874			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	79,687	9,066,315	0.008789			65
66	Physical Therapy	245,602	13,266,840	0.018512			66
67	Occupational Therapy	49,013	4,939,291	0.009923			67
68	Speech Pathology	34,293	1,985,742	0.017270			68
69	Electrocardiology	90,540	17,921,785	0.005052			69
70	Electroencephalography	29,300	1,950,929	0.015018			70
71	Medical Supplies Charged to Pat	179,475	9,188,747	0.019532			71
72	Impl. Dev. Charged to Patients	160,470	14,296,470	0.011224			72
73	Drugs Charged to Patients	356,544	26,859,929	0.013274			73
73.01	OUTPATIENT PHARMACY						73.01
74	Renal Dialysis	2,616	1,123,252	0.002329			74
76	LITHOTRIPSY						76
76.01	CARDIAC REHABILITATION	102,040	906,568	0.112556			76.01
76.02	GASTRO INTESTINAL SERVICES	25,023	12,116,330	0.002065			76.02
76.05	INPATIENT RENAL DIALYSIS						76.05
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	2,450	25,088	0.097656			90
90.01	OUTPATIENT INFUSION PROCEDURES						90.01
90.02	WOUND CARE	66,386	2,708,361	0.024512			90.02
90.03	RIVER FOREST						90.03
91	Emergency	540,042	49,532,254	0.010903			91
92	Observation Beds (Non-Distinct		9,292,209				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	5,719,179	418,859,302				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [XX] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF          [  ] NF                                     [XX] Other
```

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [XX] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF          [  ] NF                                     [XX] Other
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		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684							50
51	Recovery Room	8,589,343							51
52	Delivery Room & Labor Room	5,504,688							52
53	Anesthesiology	19,974,848							53
54	Radiology-Diagnostic	19,374,530							54
56	Radioisotope	6,418,143							56
56.01	ULTRASOUND	10,919,549							56.01
57	CT Scan	43,433,099							57
58	MRI	14,023,050							58
59	Cardiac Catheterization	11,700,461							59
60	Laboratory	81,940,797							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315							65
66	Physical Therapy	13,266,840							66
67	Occupational Therapy	4,939,291							67
68	Speech Pathology	1,985,742							68
69	Electrocardiology	17,921,785							69
70	Electroencephalography	1,950,929							70
71	Medical Supplies Charged to Pat	9,188,747							71
72	Impl. Dev. Charged to Patients	14,296,470							72
73	Drugs Charged to Patients	26,859,929							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568							76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361							90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254							91
92	Observation Beds (Non-Distinct	9,292,209							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S008** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P          [  ] Hospital     [  ] SUB (Other)          [  ] Swing Bed SNF
Applicable   [  ] Title XVIII, Part B    [XX] IPF          [  ] SNF                  [  ] Swing Bed NF
Boxes:       [XX] Title XIX - O/P        [  ] IRF          [  ] NF                   [  ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529							50
51	Recovery Room	0.118345							51
52	Delivery Room & Labor Room	0.546669							52
53	Anesthesiology	0.008115							53
54	Radiology-Diagnostic	0.159652							54
56	Radioisotope	0.072778							56
56.01	ULTRASOUND	0.089434							56.01
57	CT Scan	0.021185							57
58	MRI	0.030692							58
59	Cardiac Catheterization	0.109961							59
60	Laboratory	0.084685							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557							65
66	Physical Therapy	0.184260							66
67	Occupational Therapy	0.099253							67
68	Speech Pathology	0.208160							68
69	Electrocardiology	0.052628							69
70	Electroencephalography	0.100262							70
71	Medical Supplies Charged to Pat	0.835737							71
72	Impl. Dev. Charged to Patients	0.486082							72
73	Drugs Charged to Patients	0.265336							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154							76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165							91
92	Observation Beds (Non-Distinct	0.245752							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART IV**

```
Check        [  ] Title V                 [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A     [  ] IPF          [XX] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX               [  ] IRF          [  ] NF                                     [XX] Other
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		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART IV**

```
Check        [  ] Title V                [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [XX] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX              [  ] IRF          [  ] NF                                     [XX] Other
```

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,800,684							50
51	Recovery Room	8,589,343							51
52	Delivery Room & Labor Room	5,504,688							52
53	Anesthesiology	19,974,848							53
54	Radiology-Diagnostic	19,374,530							54
56	Radioisotope	6,418,143							56
56.01	ULTRASOUND	10,919,549							56.01
57	CT Scan	43,433,099							57
58	MRI	14,023,050							58
59	Cardiac Catheterization	11,700,461							59
60	Laboratory	81,940,797							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,066,315							65
66	Physical Therapy	13,266,840							66
67	Occupational Therapy	4,939,291							67
68	Speech Pathology	1,985,742							68
69	Electrocardiology	17,921,785							69
70	Electroencephalography	1,950,929							70
71	Medical Supplies Charged to Pat	9,188,747							71
72	Impl. Dev. Charged to Patients	14,296,470							72
73	Drugs Charged to Patients	26,859,929							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	1,123,252							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	906,568							76.01
76.02	GASTRO INTESTINAL SERVICES	12,116,330							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	25,088							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	2,708,361							90.02
90.03	RIVER FOREST								90.03
91	Emergency	49,532,254							91
92	Observation Beds (Non-Distinct	9,292,209							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	418,859,302							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-5526** **WORKSHEET D PART V**

```
Check        [  ] Title V - O/P          [  ] Hospital     [  ] SUB (Other)          [  ] Swing Bed SNF
Applicable   [  ] Title XVIII, Part B    [  ] IPF          [XX] SNF                  [  ] Swing Bed NF
Boxes:       [XX] Title XIX - O/P        [  ] IRF          [  ] NF                   [  ] ICF/IID
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			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.489529							50
51	Recovery Room	0.118345							51
52	Delivery Room & Labor Room	0.546669							52
53	Anesthesiology	0.008115							53
54	Radiology-Diagnostic	0.159652							54
56	Radioisotope	0.072778							56
56.01	ULTRASOUND	0.089434							56.01
57	CT Scan	0.021185							57
58	MRI	0.030692							58
59	Cardiac Catheterization	0.109961							59
60	Laboratory	0.084685							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.194557							65
66	Physical Therapy	0.184260							66
67	Occupational Therapy	0.099253							67
68	Speech Pathology	0.208160							68
69	Electrocardiology	0.052628							69
70	Electroencephalography	0.100262							70
71	Medical Supplies Charged to Pat	0.835737							71
72	Impl. Dev. Charged to Patients	0.486082							72
73	Drugs Charged to Patients	0.265336							73
73.01	OUTPATIENT PHARMACY								73.01
74	Renal Dialysis	0.298070							74
76	LITHOTRIPSY								76
76.01	CARDIAC REHABILITATION	0.635154							76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662							76.02
76.05	INPATIENT RENAL DIALYSIS								76.05
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.222656							90
90.01	OUTPATIENT INFUSION PROCEDURES								90.01
90.02	WOUND CARE	0.367536							90.02
90.03	RIVER FOREST								90.03
91	Emergency	0.117165							91
92	Observation Beds (Non-Distinct	0.245752							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART I**

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Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX - I/P        [  ] IRF          [  ] NF                                     [  ] Other
```

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,817	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,817	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	22,983	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,821	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 XIX only)		15
16	Nursery days (title V or 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)	20,802,710	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 (line 21 minus line 26)	20,802,710	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	20,802,710	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**		**[ ] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	805.78	38
39	Program general inpatient routine service cost (line 9 x line 38)	8,719,345	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)	8,719,345	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)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	5,238,534	2,362	2,217.84	1,007	2,233,365	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,457,066	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	23,409,776	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,157,429	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	889,812	51
52	Total Program excludable cost (sum of lines 50 and 51)	2,047,241	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	21,362,535	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,834	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					805.78	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,283,581	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	2,226,633	20,802,710	0.107036	2,283,581	244,425	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART I**

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Check        [  ] Title V - I/P          [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A    [XX] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [  ] Title XIX - I/P        [  ] IRF          [  ] NF                                     [  ] Other
```

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,155	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,155	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,155	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,985	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 XIX only)		15
16	Nursery days (title V or 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)	2,109,862	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 (line 21 minus line 26)	2,109,862	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	2,109,862	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART II**

```
Check        [  ] Title V - I/P          [  ] Hospital     [  ] SUB (Other)          [XX] PPS
Applicable   [XX] Title XVIII, Part A    [XX] IPF                                    [  ] TEFRA
Boxes:       [  ] Title XIX - I/P        [  ] IRF                                    [  ] Other
```

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	668.74	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,996,189	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)	1,996,189	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	167,935	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,164,124	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	183,070	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,573	51
52	Total Program excludable cost (sum of lines 50 and 51)	194,643	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,969,481	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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PART I**

```
Check        [  ] Title V - I/P        [  ] Hospital     [  ] SUB (Other)        [  ] ICF/IID      [XX] PPS
Applicable   [XX] Title XVIII, Part A  [  ] IPF          [XX] SNF                                  [  ] TEFRA
Boxes:       [  ] Title XIX - I/P      [  ] IRF          [  ] NF                                   [  ] Other
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,562	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,562	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,562	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,206	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 XIX only)		15
16	Nursery days (title V or 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)	6,195,014	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 (line 21 minus line 26)	6,195,014	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	6,195,014	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PARTS III & IV**

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
Boxes:	**[ ] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,195,014	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	647.88	71
72	Program routine service cost (line 9 x line 71)	4,668,623	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	4,668,623	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	4,668,623	83
84	Program inpatient ancillary services (see instructions)	1,689,919	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	6,358,542	86

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART I**

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Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF          [  ] NF                                     [XX] Other
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PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,817	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,817	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	22,983	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	845	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 XIX only)	1,528	15
16	Nursery days (title V or XIX only)	155	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)	20,802,710	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 (line 21 minus line 26)	20,802,710	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	20,802,710	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PART II**

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Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF                                    [XX] Other
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PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					805.78	38
39	Program general inpatient routine service cost (line 9 x line 38)					680,884	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)					680,884	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)	1,091,351	1,528	714.23	155	110,706	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	5,238,534	2,362	2,217.84	96	212,913	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,643,426	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,647,929	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	100,145	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	129,422	51
52	Total Program excludable cost (sum of lines 50 and 51)	229,567	52
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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0008** **WORKSHEET D-1 PARTS III & IV**

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Check        [  ] Title V - I/P          [XX] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [  ] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF          [  ] NF                                     [XX] Other
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PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,834	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART I**

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Check        [  ] Title V - I/P          [  ] Hospital     [  ] SUB (Other)          [  ] ICF/IID      [  ] PPS
Applicable   [  ] Title XVIII, Part A    [XX] IPF          [  ] SNF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF          [  ] NF                                     [XX] Other
```

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,155	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,155	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,155	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5	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 XIX only)		15
16	Nursery days (title V or 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)	2,109,862	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 (line 21 minus line 26)	2,109,862	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	2,109,862	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-S008** **WORKSHEET D-1 PART II**

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Check        [  ] Title V - I/P          [  ] Hospital     [  ] SUB (Other)          [  ] PPS
Applicable   [  ] Title XVIII, Part A    [XX] IPF                                    [  ] TEFRA
Boxes:       [XX] Title XIX - I/P        [  ] IRF                                    [XX] Other
```

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	668.74	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,344	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,344	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,344	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	307	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	307	52
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 (line 56 minus line 53)		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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PART I**

```
Check        [  ] Title V - I/P        [  ] Hospital     [  ] SUB (Other)        [  ] ICF/IID     [  ] PPS
Applicable   [  ] Title XVIII, Part A  [  ] IPF          [XX] SNF                                 [  ] TEFRA
Boxes:       [XX] Title XIX - I/P      [  ] IRF          [  ] NF                                  [XX] Other
```

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,562	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,562	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,562	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 (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	101	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 XIX only)		15
16	Nursery days (title V or 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)	6,195,014	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 (line 21 minus line 26)	6,195,014	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	6,195,014	37

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-5526** **WORKSHEET D-1 PARTS III & IV**

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**		**[ ] TEFRA**
Boxes:	**[XX] Title XIX - I/P**	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,195,014	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	647.88	71
72	Program routine service cost (line 9 x line 71)	65,436	72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)	65,436	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)	454,642	75
76	Per diem capital-related costs (line 75 ÷ line 2)	47.55	76
77	Program capital-related costs (line 9 x line 76)	4,803	77
78	Inpatient routine service cost (line 74 minus line 77)	60,633	78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	60,633	80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)	4,803	83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	4,803	86

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0008** **WORKSHEET D-3**

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		28,252,942		30
31	Intensive Care Unit		4,115,027		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529	3,234,516	1,583,389	50
51	Recovery Room	0.118345	1,377,289	162,995	51
52	Delivery Room & Labor Room	0.546669	16,368	8,948	52
53	Anesthesiology	0.008115	2,940,497	23,862	53
54	Radiology-Diagnostic	0.159652	2,253,353	359,752	54
56	Radioisotope	0.072778	727,325	52,933	56
56.01	ULTRASOUND	0.089434	1,220,201	109,127	56.01
57	CT Scan	0.021185	6,044,038	128,043	57
58	MRI	0.030692	1,212,847	37,225	58
59	Cardiac Catheterization	0.109961	2,346,770	258,053	59
60	Laboratory	0.084685	12,781,396	1,082,393	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557	3,267,787	635,771	65
66	Physical Therapy	0.184260	2,195,990	404,633	66
67	Occupational Therapy	0.099253	777,244	77,144	67
68	Speech Pathology	0.208160	166,772	34,715	68
69	Electrocardiology	0.052628	4,120,476	216,852	69
70	Electroencephalography	0.100262	148,552	14,894	70
71	Medical Supplies Charged to Patients	0.835737	2,225,718	1,860,115	71
72	Impl. Dev. Charged to Patients	0.486082	4,734,610	2,301,409	72
73	Drugs Charged to Patients	0.265336	6,500,056	1,724,699	73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070	412,507	122,956	74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154	264	168	76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662	1,167,818	147,918	76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536	4,206	1,546	90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165	6,618,792	775,491	91
92	Observation Beds (Non-Distinct Part)	0.245752	1,351,098	332,035	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		67,846,490	12,457,066	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		67,846,490		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S008** **WORKSHEET D-3**

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		6,447,600		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529			50
51	Recovery Room	0.118345			51
52	Delivery Room & Labor Room	0.546669	10	5	52
53	Anesthesiology	0.008115			53
54	Radiology-Diagnostic	0.159652	26,387	4,213	54
56	Radioisotope	0.072778			56
56.01	ULTRASOUND	0.089434	9,759	873	56.01
57	CT Scan	0.021185	58,766	1,245	57
58	MRI	0.030692	37,288	1,144	58
59	Cardiac Catheterization	0.109961	4,381	482	59
60	Laboratory	0.084685	462,557	39,172	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557	45,882	8,927	65
66	Physical Therapy	0.184260	139,896	25,777	66
67	Occupational Therapy	0.099253	24,986	2,480	67
68	Speech Pathology	0.208160	14,331	2,983	68
69	Electrocardiology	0.052628	12,496	658	69
70	Electroencephalography	0.100262	9,203	923	70
71	Medical Supplies Charged to Patients	0.835737	2,475	2,068	71
72	Impl. Dev. Charged to Patients	0.486082			72
73	Drugs Charged to Patients	0.265336	240,641	63,851	73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662			76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165	112,095	13,134	91
92	Observation Beds (Non-Distinct Part)	0.245752			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,201,153	167,935	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,201,153		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5526** **WORKSHEET D-3**

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[ ] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529	20,296	9,935	50
51	Recovery Room	0.118345	70	8	51
52	Delivery Room & Labor Room	0.546669	45	25	52
53	Anesthesiology	0.008115	37,850	307	53
54	Radiology-Diagnostic	0.159652	135,305	21,602	54
56	Radioisotope	0.072778	14,112	1,027	56
56.01	ULTRASOUND	0.089434	119,670	10,703	56.01
57	CT Scan	0.021185	160,877	3,408	57
58	MRI	0.030692	36,273	1,113	58
59	Cardiac Catheterization	0.109961	23,301	2,562	59
60	Laboratory	0.084685	822,623	69,664	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557	517,732	100,728	65
66	Physical Therapy	0.184260	3,236,635	596,382	66
67	Occupational Therapy	0.099253	2,102,117	208,641	67
68	Speech Pathology	0.208160	747,244	155,546	68
69	Electrocardiology	0.052628	94,726	4,985	69
70	Electroencephalography	0.100262	4,753	477	70
71	Medical Supplies Charged to Patients	0.835737	291,965	244,006	71
72	Impl. Dev. Charged to Patients	0.486082			72
73	Drugs Charged to Patients	0.265336	971,428	257,755	73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662			76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165	8,920	1,045	91
92	Observation Beds (Non-Distinct Part)	0.245752			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,345,942	1,689,919	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,345,942		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0008** **WORKSHEET D-3**

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[XX] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		3,904,552		30
31	Intensive Care Unit		896,880		31
40	Subprovider - IPF				40
43	Nursery		2,027,370		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529	485,830	237,828	50
51	Recovery Room	0.118345	189,784	22,460	51
52	Delivery Room & Labor Room	0.546669			52
53	Anesthesiology	0.008115	589,789	4,786	53
54	Radiology-Diagnostic	0.159652	297,139	47,439	54
56	Radioisotope	0.072778	81,870	5,958	56
56.01	ULTRASOUND	0.089434	193,763	17,329	56.01
57	CT Scan	0.021185	1,004,551	21,281	57
58	MRI	0.030692	114,161	3,504	58
59	Cardiac Catheterization	0.109961	234,099	25,742	59
60	Laboratory	0.084685	2,422,947	205,187	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557	680,737	132,442	65
66	Physical Therapy	0.184260	153,381	28,262	66
67	Occupational Therapy	0.099253	68,307	6,780	67
68	Speech Pathology	0.208160	9,285	1,933	68
69	Electrocardiology	0.052628	438,603	23,083	69
70	Electroencephalography	0.100262	15,495	1,554	70
71	Medical Supplies Charged to Patients	0.835737	221,237	184,896	71
72	Impl. Dev. Charged to Patients	0.486082	303,752	147,648	72
73	Drugs Charged to Patients	0.265336	1,134,846	301,115	73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662	136,371	17,273	76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165	1,250,631	146,530	91
92	Observation Beds (Non-Distinct Part)	0.245752	245,758	60,396	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		10,272,336	1,643,426	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		10,272,336		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S008** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[XX] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529			50
51	Recovery Room	0.118345			51
52	Delivery Room & Labor Room	0.546669			52
53	Anesthesiology	0.008115			53
54	Radiology-Diagnostic	0.159652			54
56	Radioisotope	0.072778			56
56.01	ULTRASOUND	0.089434			56.01
57	CT Scan	0.021185			57
58	MRI	0.030692			58
59	Cardiac Catheterization	0.109961			59
60	Laboratory	0.084685			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557			65
66	Physical Therapy	0.184260			66
67	Occupational Therapy	0.099253			67
68	Speech Pathology	0.208160			68
69	Electrocardiology	0.052628			69
70	Electroencephalography	0.100262			70
71	Medical Supplies Charged to Patients	0.835737			71
72	Impl. Dev. Charged to Patients	0.486082			72
73	Drugs Charged to Patients	0.265336			73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662			76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165			91
92	Observation Beds (Non-Distinct Part)	0.245752			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-5526** **WORKSHEET D-3**

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
Applicable	**[ ] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[XX] Title XIX**	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.489529			50
51	Recovery Room	0.118345			51
52	Delivery Room & Labor Room	0.546669			52
53	Anesthesiology	0.008115			53
54	Radiology-Diagnostic	0.159652			54
56	Radioisotope	0.072778			56
56.01	ULTRASOUND	0.089434			56.01
57	CT Scan	0.021185			57
58	MRI	0.030692			58
59	Cardiac Catheterization	0.109961			59
60	Laboratory	0.084685			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.194557			65
66	Physical Therapy	0.184260			66
67	Occupational Therapy	0.099253			67
68	Speech Pathology	0.208160			68
69	Electrocardiology	0.052628			69
70	Electroencephalography	0.100262			70
71	Medical Supplies Charged to Patients	0.835737			71
72	Impl. Dev. Charged to Patients	0.486082			72
73	Drugs Charged to Patients	0.265336			73
73.01	OUTPATIENT PHARMACY				73.01
74	Renal Dialysis	0.298070			74
76	LITHOTRIPSY				76
76.01	CARDIAC REHABILITATION	0.635154			76.01
76.02	GASTRO INTESTINAL SERVICES	0.126662			76.02
76.05	INPATIENT RENAL DIALYSIS				76.05
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.222656			90
90.01	OUTPATIENT INFUSION PROCEDURES				90.01
90.02	WOUND CARE	0.367536			90.02
90.03	RIVER FOREST				90.03
91	Emergency	0.117165			91
92	Observation Beds (Non-Distinct Part)	0.245752			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	22,056,046			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	23,273			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	5,960,028			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	172.68			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)	2.54			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.	0.57			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)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 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 line 8 plus lines (8.01 and 8.02) (see instructions)	1.97			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	4.43			10
11	FTE count for residents in dental and podiatric programs	0.05			11
12	Current year allowable FTE (see instructions)	2.02			12
13	Total allowable FTE count for the prior year	1.97			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1.97			14
15	Sum of lines 12 through 14 divided by 3	1.99			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	1.99			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.011524			19
20	Prior year resident to bed ratio (see instructions)	0.009690			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.009690			21
22	IME payment adjustment (see instructions)	116,522			22
22.01	IME payment adjustment - Managed Care (see instructions)	31,487			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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)	2.46			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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	116,522			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	31,487			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0364			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.1934			31
32	Sum of lines 30 and 31	0.2298			32
33	Allowable disproportionate share percentage (see instructions)	0.0817			33
34	Disproportionate share adjustment (see instructions)	450,495			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,354,937		1,193,185	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	341,519		893,259	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,234,778			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, 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
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
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 41.01 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 41.01)				46

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	23,881,114			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 (see instructions)	23,912,601			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,868,574			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	61,101			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	1,036			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	25,843,312			59
60	Primary payer payments	3,712			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	25,839,600			61
62	Deductibles billed to program beneficiaries	2,403,772			62
63	Coinsurance billed to program beneficiaries	96,117			63
64	Allowable bad debts (see instructions)	521,890			64
65	Adjusted reimbursable bad debts (see instructions)	339,229			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	347,815			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	23,678,940			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-72,572			70.93
70.94	HRR adjustment amount (see instructions)	-45,528			70.94
71	Amount due provider (see instructions)	23,560,840			71
71.01	Sequestration adjustment (see instructions)	471,217			71.01
72	Interim payments	22,597,097			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	492,526			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	616,539			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. 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

	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100

	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0008** **WORKSHEET E PART B**

Check applicable box: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF**

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	18,608			1
2	Medical and other services reimbursed under OPPS (see instructions)	7,576,623			2
3	PPS payments	8,799,140			3
4	Outlier payment (see instructions)	2,687			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	18,608			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	37,083			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	37,083			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	37,083			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	18,475			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	18,608			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	8,801,827			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	3,075			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,833,822			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6,983,538			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	13,570			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	6,997,108			30
31	Primary payer payments	8,860			31
32	Subtotal (line 30 minus line 31)	6,988,248			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	430,024			34
35	Adjusted reimbursable bad debts (see instructions)	279,516			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,173			36
37	Subtotal (see instructions)	7,267,764			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	7,267,764			40
40.01	Sequestration adjustment (see instructions)	145,355			40.01
41	Interim payments	6,833,823			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	288,586			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	86,353			44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S008** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [XX] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5526** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [XX] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-0008** **WORKSHEET E-1 PART I**

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Check        [XX] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [  ] SNF
Boxes:       [  ] IRF          [  ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				22,604,788		6,833,823	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	02/18/2016	7,691			3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-7,691			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				22,597,097		6,833,823	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		492,526		288,586	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				23,089,623		7,122,409	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S008** **WORKSHEET E-1 PART I**

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Check        [  ] Hospital     [  ] SUB (Other)
Applicable   [XX] IPF          [  ] SNF
Boxes:       [  ] IRF          [  ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,600,482			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,600,482			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		23,802			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,624,284			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-5526** **WORKSHEET E-1 PART I**

```
Check        [  ] Hospital     [  ] SUB (Other)
Applicable   [  ] IPF          [XX] SNF
Boxes:       [  ] IRF          [  ] Swing Bed SNF
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				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				3,577,145			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				3,577,145			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		26,850			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				3,603,995			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

Check applicable box: **[XX] Hospital** **[ ] CAH**

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 (Wkst. S-3, Pt. I, col. 15, line 14)	6,432	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	11,828	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	3,475	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	25,345	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	503,780,216	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,181,594	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	463,381	8
9	Sequestration adjustment amount (see instructions)	9,268	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	454,113	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	454,113	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S008** **WORKSHEET E-3 PART II**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	2,789,192	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	8.620219	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,789,192	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	2,789,192	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	2,789,192	18
19	Deductibles	123,284	19
20	Subtotal (line 18 minus line 19)	2,665,908	20
21	Coinsurance	12,355	21
22	Subtotal (line 20 minus line 21)	2,653,553	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,366	23
24	Adjusted reimbursable bad debts (see instructions)	24,288	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	27,456	25
26	Subtotal (sum of lines 22 and 24)	2,677,841	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	2,677,841	31
31.01	Sequestration adjustment (see instructions)	53,557	31.01
32	Interim payments	2,600,482	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	23,802	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	6,442	35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART VI**

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	3,920,292	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	3,920,292	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	270,144	7
8	Allowable bad debts (see instructions)	42,150	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	8,469	9
10	Adjusted reimbursable bad debts (see instructions)	27,398	10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	3,677,546	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	3,677,546	15
15.01	Sequestration adjustment (see instructions)	73,551	15.01
16	Interim payments	3,577,145	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	26,850	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	21,893	19

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0008** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	[ ] Title V	[XX] Hospital	[ ] NF	[ ] PPS
	[XX] Title XIX	[ ] SUB (Other)	[ ] ICF/IID	[ ] TEFRA
		[ ] SNF		[XX] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,647,929		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,647,929		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,647,929		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	6,892,559		8
9	Ancillary service charges	10,272,336		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	17,164,895		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	17,164,895		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	14,516,966		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	2,647,929		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	2,647,929		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	2,647,929		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	2,647,929		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	2,647,929		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	2,647,929		40
41	Interim payments	2,647,929		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S008** **WORKSHEET E-3 PART VII**

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Check        [  ] Title V          [  ] Hospital          [  ] NF          [  ] PPS
Applicable   [XX] Title XIX        [XX] Subprovider IPF   [  ] ICF/IID     [  ] TEFRA
Boxes:                             [  ] SNF                                [XX] Other
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PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	3,344		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	3,344		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,344		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	3,344		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	3,344		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-5526** **WORKSHEET E-3 PART VII**

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Check        [  ] Title V          [  ] Hospital          [  ] NF          [  ] PPS
Applicable   [XX] Title XIX        [  ] SUB (Other)       [  ] ICF/IID     [  ] TEFRA
Boxes:                             [XX] SNF                                [XX] Other
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PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	4,803		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	4,803		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	4,803		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	4,803		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	4,803		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

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Check        [  ] Title V
Applicable   [XX] Title XVIII
Box:         [  ] Title XIX
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	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1.54	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			0.23	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			1.31	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.43	6
7	Enter the lesser of line 5 or line 6			1.31	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	2.09	2.27	4.36	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.62	0.67	1.29	9
10	Weighted dental and podiatric resident FTE count for the current year		0.05		10
11	Total weighted FTE count	0.62	0.72		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.94	0.33		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.99	0.32		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.85	0.46		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.85	0.46		17
18	Per resident amount	91,718.67	91,718.67		18
19	Approved amount for resident costs	77,961	42,191	120,152	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)			3.12	21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			120,152	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	14,813	3,580		26
27	Total inpatient days (see instructions)	28,782	28,782		27
28	Ratio of inpatient days to total inpatient days	0.514662	0.124383		28
29	Program direct GME amount	61,838	14,945		29
30	Reduction for direct GME payments for Medicare Advantage		2,112		30
31	Net Program direct GME amount			74,671	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			1,123,252	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			34,162,815	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			3,712	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			34,159,103	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			7,595,231	42
43	Primary payer payments (see instructions)			8,860	43
44	Total Part B reasonable cost (line 42 minus line 43)			7,586,371	44
45	Total reasonable cost (sum of lines 41 and 44)			41,745,474	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.818271	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.181729	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			74,671	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			61,101	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			13,570	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

```
Check        [  ] Title V
Applicable   [  ] Title XVIII
Box:         [XX] Title XIX
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	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	946	4,178		26
27	Total inpatient days (see instructions)	28,782	28,782		27
28	Ratio of inpatient days to total inpatient days	0.032868	0.145160		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,545,612				1
2	Temporary investments	16,713,180				2
3	Notes receivable					3
4	Accounts receivable	15,334,201				4
5	Other receivables	56,519,735				5
6	Allowances for uncollectible notes and accounts receivable	-2,618,770				6
7	Inventory	2,816,000				7
8	Prepaid expenses	359,246				8
9	Other current assets	2,653,729				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	94,322,933				11
	FIXED ASSETS					
12	Land	12,500,000				12
13	Land improvements	987,143				13
14	Accumulated depreciation	-272,148				14
15	Buildings	66,101,921				15
16	Accumulated depreciation	-18,490,491				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	41,871,311				23
24	Accumulated depreciation	-19,743,980				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)	82,953,756				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,739,814				34
35	Total other assets (sum of lines 31-34)	3,739,814				35
36	Total assets (sum of lines 11, 30 and 35)	181,016,503				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	52,238,369				37
38	Salaries, wages and fees payable	6,228,882				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	7,599,468				43
44	Other current liabilities	328,680				44
45	Total current liabilities (sum of lines 37 thru 44)	66,395,399				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	41,464,655				49
50	Total long term liabilities (sum of lines 46 thru 49)	41,464,655				50
51	Total liabilities (sum of lines 45 and 50)	107,860,054				51
	CAPITAL ACCOUNTS					
52	General fund balance	73,156,449				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	73,156,449				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	181,016,503				60

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		66,091,938			1
2	Net income (loss) (from Worksheet G-3, line 29)		7,064,511			2
3	Total (sum of line 1 and line 2)		73,156,449			3
4	Additions (credit adjustments) (specify)					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)		73,156,449			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		73,156,449			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	59,216,125		59,216,125	1
2	Subprovider IPF	6,795,360		6,795,360	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility	7,238,583		7,238,583	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	73,250,068		73,250,068	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	11,165,826		11,165,826	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	11,165,826		11,165,826	16
17	Total inpatient routine care services (sum of lines 10 and 16)	84,415,894		84,415,894	17
18	Ancillary services	174,154,810		174,154,810	18
19	Outpatient services		218,847,222	218,847,222	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		10,952	10,952	22
23	Ambulance				23
25	ASC				25
26	Hospice		52,327	52,327	26
27	PATIENT REVENUE NOT LISTED ABOVE		2,748,973	2,748,973	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	258,570,704	221,659,474	480,230,178	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		120,338,422	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		120,338,422	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	480,230,178	1
2	Less contractual allowances and discounts on patients' accounts	371,392,370	2
3	Net patient revenues (line 1 minus line 2)	108,837,808	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	120,338,422	4
5	Net income from service to patients (line 3 minus line 4)	-11,500,614	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	-497,331	7
8	Revenues from telephone and other miscellaneous communication services		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 medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	4,982	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	1,746,579	22
23	Governmental appropriations		23
24	Other (MEDICARE EHR INCENTIVE)	1,109,023	24
24.01	Other (REFERENCE LAB)	4,000,553	24.01
24.04	Other (NON-OP REVENUE)	12,201,319	24.04
25	Total other income (sum of lines 6-24)	18,565,125	25
26	Total (line 5 plus line 25)	7,064,511	26
29	Net income (or loss) for the period (line 26 minus line 28)	7,064,511	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7255** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General			162		24,051	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)					9,758	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)			162		33,809	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7255** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	24,213	-2,293	21,920		21,920	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)	9,758	-8,324	1,434		1,434	12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	33,971	-10,617	23,354		23,354	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7255** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	21,920				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care					6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)	1,434				12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	23,354				24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7255** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		21,920	21,920		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care					6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)		1,434	21,920	23,354	12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		23,354		23,354	24

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7255** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-21,920	2,868	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech Pathology							9
10	Medical Social Services							10
11	Home Health Aide							11
12	Supplies (see instructions)					1,434	2,868	12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-20,486	2,868	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						21,920	25
26	Unit Cost Multiplier						7.642957	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7255** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General		81,188			81,188	7,736	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies	23,354				23,354	2,225	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	23,354	81,188			104,542	9,961	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7255** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General		130,493		247,572		492	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		130,493		247,572		492	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7255** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	MAIN-TENANCE & PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		651	179				1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		651	179				20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7255** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						468,311	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies						25,579	8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)						493,890	20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7255** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS			
		25	26	27	28			
1	Administrative and General		468,311					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies		25,579	468,311	493,890			8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)		493,890	468,311	493,890			20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			18.308417				21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7255** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VAL UE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS MAINT REQS	
		1	2	4	4A	5	6	
1	Administrative and General	4,379				81,188		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies					23,354		8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	4,379				104,542		20
21	Total cost to be allocated	81,188				9,961		21
22	Unit Cost Multiplier	18.540306				0.095282		22
22	Unit Cost Multiplier							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7255** **WORKSHEET H-2 PART II**

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY)	HOUSE-KEEPING HOURS OF SERVICE)	DIETARY MEALS SERVED)	CAFETERIA FTES SERVED)	MAIN-TENANCE & PERSONNEL FTES SERVED)	
		7	8	9	10	11	12	
1	Administrative and General	4,379		1,234		12		1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	4,379		1,234		12		20
21	Total cost to be allocated	130,493		247,572		492		21
22	Unit Cost Multiplier	29.799726		200.625608		41.000000		22
22	Unit Cost Multiplier							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7255** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING ADMINIS-TRATION FTES SERVED)	CENTRAL SERVICES & SUPPLY COSTED REQUIS)	PHARMACY COSTED REQUIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	SOCIAL SERVICE TIME SPENT)	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	5	1,522					1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	5	1,522					20
21	Total cost to be allocated	651	179					21
22	Unit Cost Multiplier	130.200000						22
22	Unit Cost Multiplier		0.117608					22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7255** **WORKSHEET H-2 PART II**

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7255** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2				205		1
2	Physical Therapy	3		1,096	1,096	1,007	1.09	2
3	Occupational Therapy	4		-24	-24	3	-8.00	3
4	Speech Pathology	5						4
5	Medical Social Services	6				12		5
6	Home Health Aide	7				50		6
7	Total (sum of lines 1-6)			1,072	1,072	1,277		7

Limitation Cost Comoputation			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	16974		205		8
9	Physical Therapy	16974		107		9
10	Occupational Therapy	16974		3		10
11	Speech Pathology	16974				11
12	Medical Social Services	16974		12		12
13	Home Health Aide	16974		50		13
14	Total (sum of lines 8-13)			377		14

Supplies and Drugs Cost Computations								
	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8	493,890	1,718	495,608			15
16	Cost of Drugs	9						16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.184260	5,950	1,096	col. 2, line 2	1
2	Occupational Therapy	67	0.099253	-240	-24	col. 2, line 3	2
3	Speech Pathology	68	0.208160			col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.835737	2,056	1,718	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.265336			col. 2, line 16	5
5.01	OUTPATIENT PHARMACY	73.01				col. 2, line 16	5.01

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7255** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		205						1
2	Physical Therapy		107			117		117	2
3	Occupational Therapy		3			-24		-24	3
4	Speech Pathology								4
5	Medical Social Services		12						5
6	Home Health Aide		50						6
7	Total (sum of lines 1-6)		377			93		93	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7255** **WORKSHEET H-4 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		33,493	11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes		264	13
14	Total PPS Reimbursement - PEP Episodes		14,262	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PSP Episodes		1,710	16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)		49,729	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		49,729	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		49,729	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		49,729	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		49,729	31
31.01	Sequestration adjustment (see instructions)		995	31.01
32	Interim payments (see instructions)		48,734	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7255** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						48,734	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.							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						48,734	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						48,734	7
8	Name of Contractor			Contractor Number		NPR Date: Month, Day, Year		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS **HOSPICE CCN: 14-1561** **WORKSHEET K**

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR-TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	481				4,146	6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	537					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy	4					12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services	69					15
16	Spiritual Counseling	43					16
17	Dietary Counseling						17
18	Counseling - Other	80					18
19	Home Health Aide and Homemaker	66					19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy					377	22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	1,280				4,523	39

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS **HOSPICE CCN: 14-1561** **WORKSHEET K**

		TOTAL (cols. 1-5)	RECLASSI-FICATION	SUBTOTAL (col. 6 ± col. 7)	ADJUST-MENTS	TOTAL (col. 8 ± col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	4,627	-3,597	1,030		1,030	6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	537		537		537	10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy	4		4		4	12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services	69		69		69	15
16	Spiritual Counseling	43		43		43	16
17	Dietary Counseling						17
18	Counseling - Other	80		80		80	18
19	Home Health Aide and Homemaker	66		66		66	19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy	377	-377				22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	5,803	-7,948	1,829		1,829	39

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES **HOSPICE CCN: 14-1561** **WORKSHEET K-1**

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	-3			193	259	6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	-3			215	289	10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy				2	2	12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services				27	37	15
16	Spiritual Counseling				17	23	16
17	Dietary Counseling						17
18	Counseling - Other				32	43	18
19	Home Health Aide and Homemaker				27	34	19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	-6			513	687	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES **HOSPICE CCN: 14-1561** **WORKSHEET K-1**

		TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		6	7	8	9	
	GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fixt.					1
2	Capital Related Costs-Movable Eqiup.					2
3	Plant Operation and Maintenance					3
4	Transportation - Staff					4
5	Volunteer Service Coordination					5
6	Administrative and General		32		481	6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care		36		537	10
11	Nursing Care-Continuous Home Care					11
12	Physical Therapy				4	12
13	Occupational Therapy					13
14	Speech / Language Pathology					14
15	Medical Social Services		5		69	15
16	Spiritual Counseling		3		43	16
17	Dietary Counseling					17
18	Counseling - Other		5		80	18
19	Home Health Aide and Homemaker		5		66	19
20	HH Aide & Homemaker - Cont. Home Care					20
21	Other					21
	OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion Therapy					22
23	Analgesics					23
24	Sedatives / Hypnotics					24
25	Other - Specify					25
26	Durable Medical Equipment/Oxygen					26
27	Patient Transportation					27
28	Imaging Services					28
29	Labs and Diagnostics					29
30	Medical Supplies					30
31	Outpatient Services (including E/R Dept.)					31
32	Radiation Therapy					32
33	Chemotherapy					33
34	Other					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs					35
36	Volunteer Program Costs					36
37	Fundraising					37
38	Other Program Costs					38
39	Total (sum of lines 1-38)		86		1,280	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) **HOSPICE CCN: 14-1561** **WORKSHEET K-2**

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General						6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care						10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED) **HOSPICE CCN: 14-1561** **WORKSHEET K-2**

		TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		6	7	8	9	
	GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fixt.					1
2	Capital Related Costs-Movable Eqiup.					2
3	Plant Operation and Maintenance					3
4	Transportation - Staff					4
5	Volunteer Service Coordination					5
6	Administrative and General					6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care					10
11	Nursing Care-Continuous Home Care					11
12	Physical Therapy					12
13	Occupational Therapy					13
14	Speech / Language Pathology					14
15	Medical Social Services					15
16	Spiritual Counseling					16
17	Dietary Counseling					17
18	Counseling - Other					18
19	Home Health Aide and Homemaker					19
20	HH Aide & Homemaker - Cont. Home Care					20
21	Other					21
	OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion Therapy					22
23	Analgesics					23
24	Sedatives / Hypnotics					24
25	Other - Specify					25
26	Durable Medical Equipment/Oxygen					26
27	Patient Transportation					27
28	Imaging Services					28
29	Labs and Diagnostics					29
30	Medical Supplies					30
31	Outpatient Services (including E/R Dept.)					31
32	Radiation Therapy					32
33	Chemotherapy					33
34	Other					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs					35
36	Volunteer Program Costs					36
37	Fundraising					37
38	Other Program Costs					38
39	Total (sum of lines 1-38)					39

(1) Transfer the amount in column 9 to Wkst. K, column 2.

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES **HOSPICE CCN: 14-1561** **WORKSHEET K-3**

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS-TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General						6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care						10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy						12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services						15
16	Spiritual Counseling						16
17	Dietary Counseling						17
18	Counseling - Other						18
19	Home Health Aide and Homemaker						19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES **HOSPICE CCN: 14-1561** **WORKSHEET K-3**

		TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		6	7	8	9	
	GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fixt.					1
2	Capital Related Costs-Movable Eqiup.					2
3	Plant Operation and Maintenance					3
4	Transportation - Staff					4
5	Volunteer Service Coordination					5
6	Administrative and General					6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care					10
11	Nursing Care-Continuous Home Care					11
12	Physical Therapy					12
13	Occupational Therapy					13
14	Speech / Language Pathology					14
15	Medical Social Services					15
16	Spiritual Counseling					16
17	Dietary Counseling					17
18	Counseling - Other					18
19	Home Health Aide and Homemaker					19
20	HH Aide & Homemaker - Cont. Home Care					20
21	Other					21
	OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion Therapy					22
23	Analgesics					23
24	Sedatives / Hypnotics					24
25	Other - Specify					25
26	Durable Medical Equipment/Oxygen					26
27	Patient Transportation					27
28	Imaging Services					28
29	Labs and Diagnostics					29
30	Medical Supplies					30
31	Outpatient Services (including E/R Dept.)					31
32	Radiation Therapy					32
33	Chemotherapy					33
34	Other					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs					35
36	Volunteer Program Costs					36
37	Fundraising					37
38	Other Program Costs					38
39	Total (sum of lines 1-38)					39

(1) Transfer the amount in column 9 to Wkst. K, column 4.

COST ALLOCATION - HOSPICE GENERAL SERVICE COST **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART I**

			CAPITAL RELATED COSTS				
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANS-PORTATION	
		0	1	2	3	4	
	GENERAL SERVICE COST CENTER						
1	Capital Related Costs-Bldg and Fixt.						1
2	Capital Related Costs-Movable Eqiup.						2
3	Plant Operation and Maintenance						3
4	Transportation - Staff						4
5	Volunteer Service Coordination						5
6	Administrative and General	1,030					6
	INPATIENT CARE SERVICE						
7	Inpatient - General Care						7
8	Inpatient - Respite Care						8
	VISITING SERVICES						
9	Physician Services						9
10	Nursing Care	537					10
11	Nursing Care-Continuous Home Care						11
12	Physical Therapy	4					12
13	Occupational Therapy						13
14	Speech / Language Pathology						14
15	Medical Social Services	69					15
16	Spiritual Counseling	43					16
17	Dietary Counseling						17
18	Counseling - Other	80					18
19	Home Health Aide and Homemaker	66					19
20	HH Aide & Homemaker - Cont. Home Care						20
21	Other						21
	OTHER HOSPICE SERVICE COSTS						
22	Drugs, Biological and Infusion Therapy						22
23	Analgesics						23
24	Sedatives / Hypnotics						24
25	Other - Specify						25
26	Durable Medical Equipment/Oxygen						26
27	Patient Transportation						27
28	Imaging Services						28
29	Labs and Diagnostics						29
30	Medical Supplies						30
31	Outpatient Services (including E/R Dept.)						31
32	Radiation Therapy						32
33	Chemotherapy						33
34	Other						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	Bereavement Program Costs						35
36	Volunteer Program Costs						36
37	Fundraising						37
38	Other Program Costs						38
39	Total (sum of lines 1-38)	1,829					39

COST ALLOCATION - HOSPICE GENERAL SERVICE COST **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART I**

		VOLUNTEER SERVICES COORDI-NATOR	SUBTOTAL (cols. 0 - 5)	ADMINIS-TRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
		5	5A	6	7	
	GENERAL SERVICE COST CENTER					
1	Capital Related Costs-Bldg and Fixt.					1
2	Capital Related Costs-Movable Eqiup.					2
3	Plant Operation and Maintenance					3
4	Transportation - Staff					4
5	Volunteer Service Coordination					5
6	Administrative and General		1,030	1,030		6
	INPATIENT CARE SERVICE					
7	Inpatient - General Care					7
8	Inpatient - Respite Care					8
	VISITING SERVICES					
9	Physician Services					9
10	Nursing Care		537	693	1,230	10
11	Nursing Care-Continuous Home Care					11
12	Physical Therapy		4	5	9	12
13	Occupational Therapy					13
14	Speech / Language Pathology					14
15	Medical Social Services		69	89	158	15
16	Spiritual Counseling		43	55	98	16
17	Dietary Counseling					17
18	Counseling - Other		80	103	183	18
19	Home Health Aide and Homemaker		66	85	151	19
20	HH Aide & Homemaker - Cont. Home Care					20
21	Other					21
	OTHER HOSPICE SERVICE COSTS					
22	Drugs, Biological and Infusion Therapy					22
23	Analgesics					23
24	Sedatives / Hypnotics					24
25	Other - Specify					25
26	Durable Medical Equipment/Oxygen					26
27	Patient Transportation					27
28	Imaging Services					28
29	Labs and Diagnostics					29
30	Medical Supplies					30
31	Outpatient Services (including E/R Dept.)					31
32	Radiation Therapy					32
33	Chemotherapy					33
34	Other					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	Bereavement Program Costs					35
36	Volunteer Program Costs					36
37	Fundraising					37
38	Other Program Costs					38
39	Total (sum of lines 1-38)		1,829		1,829	39

COST ALLOCATION - HOSPICE STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-4 PART II**

		CAPITAL RELATED COSTS							
	COST CENTER DESCRIPTIONS	BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT ($ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANS-PORTATION (Mileage)	VOLUNTEER SERVICES COORDI-NATOR (Hours)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (Acc. Cost)	
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTER								
1	Capital Related Costs-Bldg and Fixt.								1
2	Capital Related Costs-Movable Eqiup.								2
3	Plant Operation and Maintenance								3
4	Transportation - Staff								4
5	Volunteer Service Coordination								5
6	Administrative and General						-1,030	1,598	6
	INPATIENT CARE SERVICE								
7	Inpatient - General Care								7
8	Inpatient - Respite Care								8
	VISITING SERVICES								
9	Physician Services								9
10	Nursing Care						537	1,074	10
11	Nursing Care-Continuous Home Care								11
12	Physical Therapy						4	8	12
13	Occupational Therapy								13
14	Speech / Language Pathology								14
15	Medical Social Services						69	138	15
16	Spiritual Counseling						43	86	16
17	Dietary Counseling								17
18	Counseling - Other						80	160	18
19	Home Health Aide and Homemaker						66	132	19
20	HH Aide & Homemaker - Cont. Home Care								20
21	Other								21
	OTHER HOSPICE SERVICE COSTS								
22	Drugs, Biological and Infusion Therapy								22
23	Analgesics								23
24	Sedatives / Hypnotics								24
25	Other - Specify								25
26	Durable Medical Equipment/Oxygen								26
27	Patient Transportation								27
28	Imaging Services								28
29	Labs and Diagnostics								29
30	Medical Supplies								30
31	Outpatient Services (including E/R Dept.)								31
32	Radiation Therapy								32
33	Chemotherapy								33
34	Other								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	Bereavement Program Costs								35
36	Volunteer Program Costs								36
37	Fundraising								37
38	Other Program Costs								38
39	Cost to be Allocated (per Wskt K-4, Part I)							1,030	39
40	Unit Cost Multiplier							0.644556	40

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
1	Administrative and General				117	117	11	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care	1,230			131	1,361	130	5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy	9			1	10	1	7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services	158			17	175	17	10
11	Spiritual Counseling	98			10	108	10	11
12	Dietary Counseling							12
13	Counseling - Other	183			20	203	19	13
14	Home Health Aide and Homemaker	151			16	167	16	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33) (2)	1,829			312	2,141	204	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6	7	8	9	10	11	
1	Administrative and General				11,235		41	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33) (2)				11,235		41	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAIN-TENANCE & PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	Administrative and General		130	18				1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33) (2)		130	18				34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (cols. 4A-23)	
		19	20	21	22	23	24	
1	Administrative and General						11,552	1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care						1,491	5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy						11	7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services						192	10
11	Spiritual Counseling						118	11
12	Dietary Counseling							12
13	Counseling - Other						222	13
14	Home Health Aide and Homemaker						183	14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33) (2)						13,769	34
35	Unit Cost Multiplier (see instructions)							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART I**

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols. 24 ± 25)	ALLOC HOSP A&G (See Part II)	TOTAL HOSP COSTS (col 26 ± 27)			
		25	26	27	28			
1	Administrative and General		11,552					1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care		1,491	7,769	9,260			5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy		11	57	68			7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services		192	1,000	1,192			10
11	Spiritual Counseling		118	615	733			11
12	Dietary Counseling							12
13	Counseling - Other		222	1,157	1,379			13
14	Home Health Aide and Homemaker		183	954	1,137			14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33) (2)		13,769		13,769			34
35	Unit Cost Multiplier (see instructions)			5.210645				35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.
(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART II**

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VAL UE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS MAINT REQS	
		1	2	4	4A	5	6	
1	Administrative and General			481		117		1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care			537		1,361		5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy			4		10		7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services			69		175		10
11	Spiritual Counseling			43		108		11
12	Dietary Counseling							12
13	Counseling - Other			80		203		13
14	Home Health Aide and Homemaker			66		167		14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33)			1,280		2,141		34
35	Total cost to be allocated			312		204		35
36	Unit Cost Multiplier (see instructions)			0.243750		0.095283		36
36	Unit Cost Multiplier (see instructions)							36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART II**

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY)	HOUSE-KEEPING HOURS OF S ERVICE)	DIETARY MEALS SERV ED)	CAFETERIA FTES SERVE D)	MAIN-TENANCE & PERSONNEL FTES SERVE D)	
		7	8	9	10	11	12	
1	Administrative and General			56		1		1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33)			56		1		34
35	Total cost to be allocated			11,235		41		35
36	Unit Cost Multiplier (see instructions)			200.625000		41.000000		36
36	Unit Cost Multiplier (see instructions)							36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART II**

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING ADMINIS-TRATION FTES SERVE D)	CENTRAL SERVICES & SUPPLY COSTED REQ UIS)	PHARMACY COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY TIME SPENT)	SOCIAL SERVICE TIME SPENT)	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	Administrative and General	1	149					1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33)	1	149					34
35	Total cost to be allocated	130	18					35
36	Unit Cost Multiplier (see instructions)	130.000000						36
36	Unit Cost Multiplier (see instructions)		0.120805					36

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART II**

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED T IME)	I&R PROGRAM COSTS ASSIGNED T IME)	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	Administrative and General							1
2	Inpatient - General Care							2
3	Inpatient - Respite Care							3
4	Physician Services							4
5	Nursing Care							5
6	Nursing Care-Continuous Home Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech / Language Pathology							9
10	Medical Social Services							10
11	Spiritual Counseling							11
12	Dietary Counseling							12
13	Counseling - Other							13
14	Home Health Aide and Homemaker							14
15	HH Aide & Homemaker - Cont. Home Care							15
16	Other							16
17	Drugs, Biological and Infusion Therapy							17
18	Analgesics							18
19	Sedatives / Hypnotics							19
20	Other - Specify							20
21	Durable Medical Equipment/Oxygen							21
22	Patient Transportation							22
23	Imaging Services							23
24	Labs and Diagnostics							24
25	Medical Supplies							25
26	Outpatient Services (including E/R Dept.)							26
27	Radiation Therapy							27
28	Chemotherapy							28
29	Other							29
30	Bereavement Program Costs							30
31	Volunteer Program Costs							31
32	Fundraising							32
33	Other Program Costs							33
34	Totals (sum of lines 1-33)							34
35	Total cost to be allocated							35
36	Unit Cost Multiplier (see instructions)							36
36	Unit Cost Multiplier (see instructions)							36

APPORTIONMENT OF HOSPICE SHARED SERVICES **HOSPICE CCN: 14-1561** **WORKSHEET K-5 PART III**

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	Wkst C, Part I, col. 9, line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	Physical Therapy	66	0.184260			1
2	Occupational Therapy	67	0.099253			2
3	Speech / Language Pathology	68	0.208160			3
4	Drugs, Biological and Infusion Therapy	73	0.265336			4
4.01	OUTPATIENT PHARMACY	73.01				4.01
5	Durable Medical Equipment/Oxygen	96				5
6	Labs and Diagnostics	60	0.084685			6
7	Medical Supplies	71	0.835737			7
8	Outpatient Services (including E/R Dept.)	93				8
9	Radiation Therapy	55				9
10	LITHOTRIPSY	76				10
10.01	CARDIAC REHABILITATION	76.01	0.635154			10.01
10.02	GASTRO INTESTINAL SERVICES	76.02	0.126662			10.02
10.05	INPATIENT RENAL DIALYSIS	76.05				10.05
10.97	CARDIAC REHABILITATION	76.97				10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98				10.98
10.99	LITHOTRIPSY	76.99				10.99
11	Totals (sum of lines 1-10)					11

CALCULATION OF HOSPICE PER DIEM COST **HOSPICE CCN: 14-1561** **WORKSHEET K-6**

	COMPUTATION OF PER DIEM COST	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	Total cost (see instructions)				13,769	1
2	Total unduplicated days (Worksheet S-9, column 6, line 5)				173	2
3	Average cost per diem (line 1 divided by line 2)				79.59	3
4	Unduplicated Medicare days (Worksheet S-9, column 1, line 5)	145				4
5	Aggregate Medicare cost (line 3 times line 4)	11,541				5
6	Unduplicated Medicaid days (Worksheet S-9, column 2, line 5)		14			6
7	Aggregate Medicaid cost (line 3 times line 6)		1,114			7
8	Unduplicated SNF days (Worksheet S-9, column 3, line 5)					8
9	Aggregate SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-9, column 4, line 5)					10
11	Aggregate NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-9, column 5, line 5)			14		12
13	Aggregate cost for other days (line 3 times line 12)			1,114		13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0008** **WORKSHEET L**

```
Check        [  ] Title V                  [XX] Hospital          [XX] PPS
Applicable   [XX] Title XVIII, Part A      [  ] SUB (Other)       [  ] Cost Method
Boxes:       [  ] Title XIX
```

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	1,767,857	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,424	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	70.32	3
4	Number of interns & residents (see instructions)	1.99	4
5	Indirect medical education percentage (see instructions)	0.80	5
6	Indirect medical education adjustment (see instructions)	14,143	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0364	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.1934	8
9	Sum of lines 7 and 8	0.2298	9
10	Allowable disproportionate share percentage (see instructions)	0.0476	10
11	Disproportionate share adjustment (see instructions)	84,150	11
12	Total prospective capital payments (see instructions)	1,868,574	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 (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (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 (from prior year Worksheet 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 COSTS FOR EXTRAORDINARY CIRCUMSTANCES **WORKSHEET L-1 PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
44	Skilled Nursing Facility							44
	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
56	Radioisotope							56
56.01	ULTRASOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
73.01	OUTPATIENT PHARMACY							73.01
74	Renal Dialysis							74
76	LITHOTRIPSY							76
76.01	CARDIAC REHABILITATION							76.01
76.02	GASTRO INTESTINAL SERVICES							76.02
76.05	INPATIENT RENAL DIALYSIS							76.05
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	OUTPATIENT INFUSION PROCEDURES							90.01
90.02	WOUND CARE							90.02
90.03	RIVER FOREST							90.03
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
116	Hospice							116
118	SUBTOTALS (sum of lines 1-117)							118

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192.01	NON-EMPLOYEE CHILD CARE CENTER							192.01
192.02	OUTPATIENT PHARMACY							192.02
192.03	WEST TOWN PHO							192.03
193	Nonpaid Workers							193
193.01	ADULT DAY CARE							193.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202