HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I & II

INTERMEDIARY USE ONLY:	[ ] AUDITED	[ ] DESK REVIEWED	DATE RECEIVED _____	INTERMEDIARY NO. _____	[XX] INITIAL	[ ] FINAL	[ ] RE-OPENING	[XX] MCR CODE 1

PART I - CERTIFICATION

CHECK APPLICABLE BOX __ ELECTRONICALLY FILED COST REPORT DATE: _____
__ MANUALLY SUBMITTED COST REPORT TIME: _____

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ORTHOPAEDIC HOSPITAL AT PARKVIEW NORTH, (15-0167) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 11/08/2007 AND ENDING 12/31/2007, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		10303		-1782	1
2	SUBPROVIDER I					2
3	SWING BED - SNF					3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	HEALTH CLINIC					9
100	TOTAL		10303		-1782	100

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1	STREET: 11119 PARKVIEW PLAZA DRIVE	P.O.BOX:	1
1.01	CITY: FORT WAYNE STATE: IN	ZIP CODE: 46845-1705 COUNTY: ALLEN	1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6	
2	HOSPITAL	ORTHOPAEDIC HOSPITAL AT PARKVIEW N	15-0167	11/08/2007	N	P	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF							4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC							14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 11/08/2007 TO: 12/31/2007	17
		1 2	
18	TYPE OF CONTROL	4	18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	9	19
20	SUBPROVIDER I		20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.		21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?	NO	21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.		21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	1 N Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	1	21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	1	21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO	22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO	23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE(mm/dd/yyyy)		23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)		23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)		23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE (mm/dd/yyyy)		23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE		23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CTR, ENTER THE CERT. DATE (mm/dd/yyyy)		23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERT. DATE (mm/dd/yyyy)		23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2		24
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO	25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO	25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO	25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO	25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO	25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	NO		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 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. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)			
28.03	STAFFING	0.00	N	28.03
28.04	RECRUITMENT	0.00	N	28.04
28.05	RETENTION OF EMPLOYEES	0.00	N	28.05
28.06	TRAINING	0.00	N	28.06
28.07	OTHER (SPECIFY)			28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	NO		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)			30.03
30.04	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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO		32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	YES	YES	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO		34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO		35

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL	V 1	XVIII 2	XIX 3	
36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	YES	NO	36
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	YES 15H032	40
40.01	NAME: PARKVIEW HEALTH SYSTEM, INC FI/CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICEFI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET: 10501 CORPORATE DRIVE P.O.BOX: 5600		40.02
40.03	CITY: STATE: IN ZIP CODE: 46895-5600		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	NO	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

		PART A 1	PART B 2	OUTPATIENT ASC 3	OUTPATIENT RADIOLOGY 4	OUTPATIENT DIAGNOSTIC 5	
47	HOSPITAL	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO	52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:		54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

		DATE 0	Y/N 1	LIMIT 2	Y/N 3	FEES 4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	NO	57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	NO	58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)		58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	59

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		60.01

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	24	1272			147		6		1
2	HMO					87		5		2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	24	1272			147		6		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	24	1272			147		6		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I									24
25	TOTAL	24								25
26	OBSERVATION BED DAYS									26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	-----I/P DAYS / O/P VISITS / TRIPS---- OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	---INTERNS & RES FTES---- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	NET 9	--FULL TIME EQUIV-- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		523								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF										3
4	HOSPITAL ADULTS & PEDS - SWING BED NF										4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		523								5
6	INTENSIVE CARE UNIT										6
7	CORONARY CARE UNIT										7
8	BURN INTENSIVE CARE UNIT										8
9	SURGICAL INTENSIVE CARE UNIT										9
10	OTHER SPECIAL CARE (SPECIFY)										10
11	NURSERY										11
12	TOTAL HOSPITAL		523						10.86		12
13	RPCH VISITS										13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY										15
16	NURSING FACILITY										16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY										18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I										24
25	TOTAL								10.86		25
26	OBSERVATION BED DAYS		29		29						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS		13								28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		53	2	193	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		53	2	193	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART II

	PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	582114		582114	22587.00	25.77		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES							8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS		385219	385219	11660.00	33.04	A-8-1 WORKPAPER	11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	745111		745111			CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	54313		54313	1612.00	33.69		22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT							24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING							26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY							27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION							30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR							33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART III

	PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	582114		582114	22587.00	25.77	1
2	EXCLUDED AREA SALARIES						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	582114		582114	22587.00	25.77	3
4	SUBTOTAL OTHER WAGES & REL COSTS		385219	385219	11660.00	33.04	4
5	SUBTOTAL WAGE-RELATED COSTS	745111		745111		128.00%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	1327225	385219	1712444	34247.00	50.00	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	54313		54313	1612.00	33.69	13

NHCMQ DEMONSTRATION STATISTICAL DATA WORKSHEET S-7
STATISTICAL DATA

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1 RATE	DAYS	SERVICES ON OR AFTER JANUARY 1 RATE	DAYS	TOTAL	
1	2	3	3.01	4	4.01	5	
1	RVC/RUC						1
2	RVB/RUB						2
3	RVA/RUA						3
3.01	RUX						3.01
3.02	RUL						3.02
4	RHD/RVC						4
5	RHC/RVB						5
6	RHB/RVA						6
6.01	RVX						6.01
6.02	RVL						6.02
7	RHA/RHC						7
8	RMC/RHB						8
9	RMB/RHA						9
9.01	RHX						9.01
9.02	RHL						9.02
10	RMA/RMC						10
11	RLB/RMB						11
12	RLA/RMA						12
12.01	RMX						12.01
12.02	RML						12.02
13	SE3/RLB						13
14	SE2/RLA						14
14.01	RLX						14.01
15	SE1/SE3						15
16	SSC/SE2						16
17	SSB/SE1						17
18	SSA/SSC						18
19	CD2/SSB						19
20	CD1/SSA						20
21	CC2						21
22	CC1						22
23	CB2						23
24	CB1						24
25	CA2						25
26	CA1						26
27	IB2						27
28	IB1						28
29	IA2						29
30	IA1						30
31	BB2						31
32	BB1						32
33	BA2						33
34	BA1						34
35	PE2						35
36	PE1						36
37	PD2						37
38	PD1						38
39	PC2						39
40	PC1						40
41	PB2						41
42	PB1						42
43	PA2						43
44	PA1						44
45	DEFAULT RATE						45
46	TOTAL						46

HOSPITAL UNCOMPENSATED CARE DATA WORKSHEET S-10

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?		1
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04		2
2.01	IS IT AT THE TIME OF ADMISSION?		2.01
2.02	IS IT AT THE TIME OF FIRST BILLING?		2.02
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?		2.03
2.04	OTHER METHODS OF WRITE-OFFS (SPECIFY)		2.04
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?		3
4	ARE CHARITY DETERMINATION BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?		4
5	ARE CHARITY DETERMINATION BASED UPON INCOME DATA ONLY?		5
6	ARE CHARITY DETERMINATION BASED UPON NET WORTH DATA?		6
7	ARE CHARITY DETERMINATION BASED UPON INCOME AND NET WORTH DATA?		7
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01		8
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?		8.01
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04		9
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?		9.01
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?		9.02
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?		9.03
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?		9.04
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE-OFF?		10
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER LINES 11 THRU 11.04		11
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?		11.01
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?		11.02
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?		11.03
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?		11.04
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?		12
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?		13
14	IS YOUR HOSPITAL STATE AND LOCAL GOVERNMENT OWNED? IF YES ANSWER LINE 14.01		14
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THE GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING UNCOMPENSATED CARE?		14.01
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?		14.02
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?		15
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?		16
17	REVENUE RELATED TO UNCOMPENSATED CARE	9205	17
17.01	GROSS MEDICAID REVENUES	429325	17.01
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS		18
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)		19
20	RESTRICTED GRANTS		20
21	NON-RESTRICTED GRANTS		21
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	438530	22
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS		23
24	COST TO CHARGE RATIO	0.478472	24
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST		25
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS		26
27	TOTAL SCHIP COST		27
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	429325	28
29	TOTAL GROSS MEDICAID COST	205420	29
30	OTHER UNCOMPENSATED CARE CHARGES (FROM YOUR RECORDS)	9205	30
31	UNCOMPENSATED CARE COST	4404	31
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	205420	32

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT				23552	23552	9153	32705	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		174355	174355		174355	154495	328850	4
5	0500	EMPLOYEE BENEFITS		183275	183275	220576	403851	-229217	174634	5
6	0600	ADMINISTRATIVE & GENERAL	54313	1068346	1122659	-243595	879064	590724	1469788	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT		57848	57848		57848		57848	8
9	0900	LAUNDRY & LINEN SERVICE								9
10	1000	HOUSEKEEPING		33964	33964		33964		33964	10
11	1100	DIETARY		21681	21681		21681		21681	11
12	1200	CAFETERIA								12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION								14
15	1500	CENTRAL SERVICES & SUPPLY		3299	3299		3299		3299	15
16	1600	PHARMACY		1153	1153		1153		1153	16
17	1700	MEDICAL RECORDS & LIBRARY						15642	15642	17
18	1800	SOCIAL SERVICE		7297	7297		7297		7297	18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	187256	19225	206481	-10235	196246		196246	25
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	275089	3010226	3285315	-2845699	439616	-115101	324515	37
40	4000	ANESTHESIOLOGY		163755	163755		163755	-140000	23755	40
41	4100	RADIOLOGY-DIAGNOSTIC		68329	68329		68329		68329	41
44	4400	LABORATORY		38150	38150		38150		38150	44
46	4600	WHOLE BLOOD & PACKED RED BLOOD		5000	5000		5000		5000	46
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900	RESPIRATORY THERAPY		15940	15940		15940		15940	49
50	5000	PHYSICAL THERAPY	65456	-15503	49953	-139	49814		49814	50
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				2855540	2855540		2855540	55
56	5600	DRUGS CHARGED TO PATIENTS		184416	184416		184416		184416	56
		OUTPATIENT SERVICE COST CENTERS								
60	6000	CLINIC		39	39		39		39	60
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC								63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
95		SUBTOTALS	582114	5040795	5622909		5622909	285696	5908605	95
		NONREIMBURSABLE COST CENTERS								
100	7950	STUDENT NURSE PROGRAM		11550	11550		11550		11550	100
101		TOTAL	582114	5052345	5634459		5634459	285696	5920155	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASSIFY BUILDING DEPRECIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		23552	1
2	TO RECLASSIFY MED AND IV SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	55		2855540	2
3		B					3
4		B					4
5	TELEPHONE EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	6		533	5
6		C					6
7		C					7
8	FRINGE BENEFITS RECLASS	D	EMPLOYEE BENEFITS	5		220576	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
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS					3100201	36

RECLASSIFICATIONS

WORKSHEET A-6
PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1		6	7	8	9	10
1	TO RECLASSIFY BUILDING DEPRECIATI	A	ADMINISTRATIVE & GENERAL	6		23552	9 1
2	TO RECLASSIFY MED AND IV SUPPLIES	B	ADULTS & PEDIATRICS	25		10145	2
3		B	OPERATING ROOM	37		2845293	3
4		B	PHYSICAL THERAPY	50		102	4
5	TELEPHONE EXPENSE RECLASS	C	ADULTS & PEDIATRICS	25		90	5
6		C	OPERATING ROOM	37		406	6
7		C	PHYSICAL THERAPY	50		37	7
8	FRINGE BENEFITS RECLASS	D	ADMINISTRATIVE & GENERAL	6		220576	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
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS					3100201	36

ANALYSIS OF CHANGES DURING COST REPORTING
PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT								6
7	SUBTOTAL								7
8	RECONCILING ITEMS								8
9	TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND								1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES								3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT		3799750		3799750	1477810	2321940	1477810	6
7	SUBTOTAL		3799750		3799750	1477810	2321940	1477810	7
8	RECONCILING ITEMS								8
9	TOTAL		3799750		3799750	1477810	2321940	1477810	9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT				.000000					3
4	NEW CAP REL COSTS-MVBLE EQUIP	2321940		2321940	1.000000					4
5	TOTAL	2321940		2321940	1.000000					5

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	32705						32705	3
4	NEW CAP REL COSTS-MVBLE EQUIP	328850						328850	4
5	TOTAL	361555						361555	5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP	174355						174355	4
5	TOTAL	174355						174355	5

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF
		1	2	3	4	5
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5	INVESTMENT INCOME-OTHER					5
6	TRADE, QUANTITY, AND TIME DISCOUNTS					6
7	REFUNDS AND REBATES OF EXPENSES					7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)					9
10	TELEVISION AND RADIO SERVICE					10
11	PARKING LOT					11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2				12
13	SALE OF SCRAP, WASTE, ETC.					13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1	804586			14
15	LAUNDRY AND LINEN SERVICE					15
16	CAFETERIA - EMPLOYEES AND GUESTS					16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19	SALE OF DRUGS TO OTHER THAN PATIENTS					19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS					20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22	VENDING MACHINES					22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34	PHYSICIANS' ASSISTANT					34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				36
37						37
38	OFFSET OTHER OPERATING ROOM REVEN	B	-115101	OPERATING ROOM	37	38
38.06	SELF-FUNDED INSURANCE OFFSET	A	-263789	EMPLOYEE BENEFITS	5	38.06
39	ANESTHESIA PROFESSIONAL FEE EXPEN	A	-140000	ANESTHESIOLOGY	40	39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL		285696			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS WORKSHEET A-8-1

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

	LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ-USTMENTS	WKST A-7 REF	
	1	2	3	4	5	6	7	
1	4	NEW CAP REL COSTS-MVBLE EQUIP	HOME OFFICE COST REPORT	154495		154495	9	1
2	6	ADMINISTRATIVE & GENERAL	HOME OFFICE COST REPORT	590724		590724		2
3	3	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE COST REPORT	9153		9153	9	3
4	5	EMPLOYEE BENEFITS	HOME OFFICE COST REPORT	34572		34572		4
4.01	17	MEDICAL RECORDS & LIBRARY	HOME OFFICE COST REPORT	15642		15642		4.01
5		TOTALS		804586		804586		5

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

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

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

	SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE: NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1	B		100.00	PARKVIEW HEALTH SYSTEM, INC		HOME OFFICE	1
2							2
3							3
4							4
5							5

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUNERA-TION INCL FRINGES 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD-JUSTED RCE LIMIT 8	PERCENT OF UNAD-JUSTED RCE LIMIT 9
101	TOTAL							

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
101	TOTAL							

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	HOUSE-KEEPING 10	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	32705	32705							3
4	NEW CAP REL COSTS-MVBLE EQUIP	328850		328850						4
5	EMPLOYEE BENEFITS	174634			174634					5
6	ADMINISTRATIVE & GENERAL	1469788			16294	1486082	1486082			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	57848				57848	19388	77236		8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	33964				33964	11383		45347	10
11	DIETARY	21681				21681	7266			11
12	CAFETERIA									12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION									14
15	CENTRAL SERVICES & SUPPLY	3299				3299	1106			15
16	PHARMACY	1153				1153	386			16
17	MEDICAL RECORDS & LIBRARY	15642				15642	5242			17
18	SOCIAL SERVICE	7297				7297	2446			18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	196246	14679	12036	56177	279138	93553	34665	20353	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	324515	16881	316280	82526	740202	248079	39867	23407	37
40	ANESTHESIOLOGY	23755				23755	7962			40
41	RADIOLOGY-DIAGNOSTIC	68329				68329	22901			41
44	LABORATORY	38150				38150	12786			44
46	WHOLE BLOOD & PACKED RED BLOOD	5000				5000	1676			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	15940				15940	5342			49
50	PHYSICAL THERAPY	49814	1145	534	19637	71130	23839	2704	1587	50
55	MEDICAL SUPPLIES CHARGED TO PAT	2855540				2855540	957036			55
56	DRUGS CHARGED TO PATIENTS	184416				184416	61807			56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	39				39	13			60
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	5908605	32705	328850	174634	5908605	1482211	77236	45347	95
	NONREIMBURSABLE COST CENTERS									
100	STUDENT NURSE PROGRAM	11550				11550	3871			100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	5920155	32705	328850	174634	5920155	1486082	77236	45347	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	DIETARY 11	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING									10
11	DIETARY	28947								11
12	CAFETERIA									12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION									14
15	CENTRAL SERVICES & SUPPLY		4405							15
16	PHARMACY			1539						16
17	MEDICAL RECORDS & LIBRARY				20884					17
18	SOCIAL SERVICE					9743				18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	28947	35		20884	9743	487318		487318	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		4370				1055925		1055925	37
40	ANESTHESIOLOGY						31717		31717	40
41	RADIOLOGY-DIAGNOSTIC						91230		91230	41
44	LABORATORY						50936		50936	44
46	WHOLE BLOOD & PACKED RED BLOOD						6676		6676	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY						21282		21282	49
50	PHYSICAL THERAPY						99260		99260	50
55	MEDICAL SUPPLIES CHARGED TO PAT						3812576		3812576	55
56	DRUGS CHARGED TO PATIENTS			1539			247762		247762	56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC						52		52	60
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	28947	4405	1539	20884	9743	5904734		5904734	95
	NONREIMBURSABLE COST CENTERS									
100	STUDENT NURSE PROGRAM						15421		15421	100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	28947	4405	1539	20884	9743	5920155		5920155	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE								9
10	HOUSEKEEPING								10
11	DIETARY								11
12	CAFETERIA								12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY								17
18	SOCIAL SERVICE								18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES A								22
23	I&R SERVICES-OTHER PRGM COSTS A								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS		14679	12036	26715	26715		26715	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		16881	316280	333161	333161		333161	37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46	WHOLE BLOOD & PACKED RED BLOOD								46
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY								49
50	PHYSICAL THERAPY		1145	534	1679	1679		1679	50
55	MEDICAL SUPPLIES CHARGED TO PAT								55
56	DRUGS CHARGED TO PATIENTS								56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS		32705	328850	361555	361555		361555	95
	NONREIMBURSABLE COST CENTERS								
100	STUDENT NURSE PROGRAM								100
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL		32705	328850	361555	361555		361555	103

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	OLD CAP BLDGS & FIXTURES SQUARE FEET 1	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT	34221							1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT		34221						3
4	NEW CAP REL COSTS-MVBLE EQUIP			1494174					4
5	EMPLOYEE BENEFITS				582114				5
6	ADMINISTRATIVE & GENERAL				54313	-1486082	4434073		6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT						57848	34221	8
9	LAUNDRY & LINEN SERVICE								9
10	HOUSEKEEPING						33964		10
11	DIETARY						21681		11
12	CAFETERIA								12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY						3299		15
16	PHARMACY						1153		16
17	MEDICAL RECORDS & LIBRARY						15642		17
18	SOCIAL SERVICE						7297		18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	15359	15359	54687	187256		279138	15359	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	17664	17664	1437060	275089		740202	17664	37
40	ANESTHESIOLOGY						23755		40
41	RADIOLOGY-DIAGNOSTIC						68329		41
44	LABORATORY						38150		44
46	WHOLE BLOOD & PACKED RED BLOO						5000		46
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY						15940		49
50	PHYSICAL THERAPY	1198	1198	2427	65456		71130	1198	50
55	MEDICAL SUPPLIES CHARGED TO P						2855540		55
56	DRUGS CHARGED TO PATIENTS						184416		56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC						39		60
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	34221	34221	1494174	582114	-1486082	4422523	34221	95
	NONREIMBURSABLE COST CENTERS								
100	STUDENT NURSE PROGRAM						11550		100
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I		32705	328850	174634		1486082	77236	103
104	UNIT COST MULT-WS B PT I		.955700		.300000		.335151		104
104	UNIT COST MULT-WS B PT I			.220088				2.256977	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III								107
108	UNIT COST MULT-WS B PT III								108
108	UNIT COST MULT-WS B PT III								108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING HOURS OF SERVICE 10	DIETARY MEALS SERVED 11	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT							3
4	NEW CAP REL COSTS-MVBLE EQUIP							4
5	EMPLOYEE BENEFITS							5
6	ADMINISTRATIVE & GENERAL							6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT							8
9	LAUNDRY & LINEN SERVICE							9
10	HOUSEKEEPING	34221						10
11	DIETARY		10000					11
12	CAFETERIA							12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION							14
15	CENTRAL SERVICES & SUPPLY			1000				15
16	PHARMACY				100			16
17	MEDICAL RECORDS & LIBRARY					10000		17
18	SOCIAL SERVICE						10000	18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES							22
23	I&R SERVICES-OTHER PRGM COSTS							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	15359	10000	8		10000	10000	25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	17664		992				37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC							41
44	LABORATORY							44
46	WHOLE BLOOD & PACKED RED BLOO							46
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY							49
50	PHYSICAL THERAPY	1198						50
55	MEDICAL SUPPLIES CHARGED TO P							55
56	DRUGS CHARGED TO PATIENTS				100			56
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERA							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
95	SUBTOTALS	34221	10000	1000	100	10000	10000	95
	NONREIMBURSABLE COST CENTERS							
100	STUDENT NURSE PROGRAM							100
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	COST TO BE ALLOC PER B PT I	45347	28947	4405	1539	20884	9743	103
104	UNIT COST MULT-WS B PT I	1.325122		4.405000		2.088400		104
104	UNIT COST MULT-WS B PT I		2.894700		15.390000		.974300	104
105	COST TO BE ALLOC PER B PT II							105
106	UNIT COST MULT-WS B PT II							106
106	UNIT COST MULT-WS B PT II							106
107	COST TO BE ALLOC PER B PT III							107
108	UNIT COST MULT-WS B PT III							108
108	UNIT COST MULT-WS B PT III							108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	487318		487318		487318	25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1055925		1055925		1055925	37
40	ANESTHESIOLOGY	31717		31717		31717	40
41	RADIOLOGY-DIAGNOSTIC	91230		91230		91230	41
44	LABORATORY	50936		50936		50936	44
46	WHOLE BLOOD & PACKED RED BL	6676		6676		6676	46
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	21282		21282		21282	49
50	PHYSICAL THERAPY	99260		99260		99260	50
55	MEDICAL SUPPLIES CHARGED TO	3812576		3812576		3812576	55
56	DRUGS CHARGED TO PATIENTS	247762		247762		247762	56
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC	52		52		52	60
62	OBSERVATION BEDS (NON-DISTI	25602		25602		25602	62
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	5930336		5930336		5930336	101
102	LESS OBSERVATION BEDS	25602		25602		25602	102
103	TOTAL	5904734		5904734		5904734	103

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	573575		573575				25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	1713713	1391143	3104856	.340088	.340088	.340088	37
40	ANESTHESIOLOGY	50541	30000	80541	.393799	.393799	.393799	40
41	RADIOLOGY-DIAGNOSTIC	97610	39180	136790	.666935	.666935	.666935	41
44	LABORATORY	127589	17139	144728	.351943	.351943	.351943	44
46	WHOLE BLOOD & PACKED RED BL	12785	792	13577	.491714	.491714	.491714	46
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
49	RESPIRATORY THERAPY	28098	4522	32620	.652422	.652422	.652422	49
50	PHYSICAL THERAPY	187432	1522	188954	.525313	.525313	.525313	50
55	MEDICAL SUPPLIES CHARGED TO	6401566	1000153	7401719	.515093	.515093	.515093	55
56	DRUGS CHARGED TO PATIENTS	475792	152004	627796	.394654	.394654	.394654	56
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	144		144	.361111	.361111	.361111	60
62	OBSERVATION BEDS (NON-DISTI		35503	35503	.721122	.721122	.721122	62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	9668845	2671958	12340803				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	9668845	2671958	12340803				103

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL CAPITAL RELATED COST 1	OLD CAPITAL SWING-BED ADJUSTMENT 2	OLD CAPITAL REDUCED CAPITAL RELATED COST 3	NEW CAPITAL CAPITAL RELATED COST 4	NEW CAPITAL SWING-BED ADJUSTMENT 5	NEW CAPITAL REDUCED CAPITAL RELATED COST 6	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				26715		26715	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL				26715		26715	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	OLD CAPITAL INPATIENT PROGRAM CAPITAL COST 10	NEW CAPITAL PER DIEM 11	NEW CAPITAL INPATIENT PROGRAM CAPITAL COST 12	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	552	147			48.40	7115	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL	552	147				7115	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES							
[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB III	[XX]	PPS
[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SUB IV	[ ]	TEFRA
[ ]	TITLE XIX	[ ]	SUB II				

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	333161	3104856	450591				.107303	48350	37
40	ANESTHESIOLOGY		80541	22970						40
41	RADIOLOGY-DIAGNOSTIC		136790	26484						41
44	LABORATORY		144728	38547						44
46	WHOLE BLOOD & PACKED RED BLOO		13577	6694						46
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY		32620	11028						49
50	PHYSICAL THERAPY	1679	188954	55286				.008886	491	50
55	MEDICAL SUPPLIES CHARGED TO P		7401719	1488124						55
56	DRUGS CHARGED TO PATIENTS		627796	358522						56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC		144	144						60
62	OBSERVATION BEDS (NON-DISTINC	1404	35503					.039546		62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL	336244	11767228	2458390					48841	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					552		147		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					552		147		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES									
	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS
		1	1.01	2	2.01	2.02	2.03	3
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM							37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC							41
44	LABORATORY							44
46	WHOLE BLOOD & PACKED RED BLOO							46
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY							49
50	PHYSICAL THERAPY							50
55	MEDICAL SUPPLIES CHARGED TO P							55
56	DRUGS CHARGED TO PATIENTS							56
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
101	TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES								
	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		3104856			450591		117683	37
40	ANESTHESIOLOGY		80541			22970		15115	40
41	RADIOLOGY-DIAGNOSTIC		136790			26484		3961	41
44	LABORATORY		144728			38547		1660	44
46	WHOLE BLOOD & PACKED RED BLOO		13577			6694		582	46
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		32620			11028		245	49
50	PHYSICAL THERAPY		188954			55286			50
55	MEDICAL SUPPLIES CHARGED TO P		7401719			1488124		62556	55
56	DRUGS CHARGED TO PATIENTS		627796			358522		69696	56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC		144			144			60
62	OBSERVATION BEDS (NON-DISTINC		35503					7510	62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		11767228			2458390		279008	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES								
	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF		
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46	WHOLE BLOOD & PACKED RED BLOO						46
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
55	MEDICAL SUPPLIES CHARGED TO P						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	TOTAL						101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	--------- PROGRAM CHARGES ---------- OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.340088	.340088	.340088				37
40	ANESTHESIOLOGY	.393799	.393799	.393799				40
41	RADIOLOGY-DIAGNOSTIC	.666935	.666935	.666935				41
44	LABORATORY	.351943	.351943	.351943				44
46	WHOLE BLOOD & PACKED RED BLOOD	.491714	.491714	.491714				46
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.652422	.652422	.652422				49
50	PHYSICAL THERAPY	.525313	.525313	.525313				50
55	MEDICAL SUPPLIES CHARGED TO PAT	.515093	.515093	.515093				55
56	DRUGS CHARGED TO PATIENTS	.394654	.394654	.394654				56
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	.361111	.361111	.361111				60
62	OBSERVATION BEDS (NON-DISTINCT	.721122	.721122	.721122				62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65.01	AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.							65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.394654	1
2	PROGRAM VACCINE CHARGES		2
2.01	PROGRAM VACCINE CHARGES		2.01
3	PROGRAM COSTS		3
3.01	PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES						
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES: ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES: ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST: OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST: OUTPATIENT RADIOLOGY 7	PROGRAM COST: OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		117683							37
40	ANESTHESIOLOGY		15115							40
41	RADIOLOGY-DIAGNOSTIC		3961							41
44	LABORATORY		1660							44
46	WHOLE BLOOD & PACKED RED BLOOD		582							46
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY		245							49
50	PHYSICAL THERAPY									50
55	MEDICAL SUPPLIES CHARGED TO PA		62556							55
56	DRUGS CHARGED TO PATIENTS		69696							56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
62	OBSERVATION BEDS (NON-DISTINCT		7510							62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65.01	AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL		279008							101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES		279008							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST: ALL OTHER (COLS 1x5) 9	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST: ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.04) 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		40023						37
40	ANESTHESIOLOGY		5952						40
41	RADIOLOGY-DIAGNOSTIC		2642						41
44	LABORATORY		584						44
46	WHOLE BLOOD & PACKED RED BLOOD		286						46
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY		160						49
50	PHYSICAL THERAPY								50
55	MEDICAL SUPPLIES CHARGED TO PAT		32222						55
56	DRUGS CHARGED TO PATIENTS		27506						56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
62	OBSERVATION BEDS (NON-DISTINCT		5416						62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65.01	AMBULANCE CHARGES (S-2 LINE 56.								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL		114791						101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES		114791						104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL CAPITAL RELATED COST 1	OLD CAPITAL SWING-BED ADJUSTMENT 2	OLD CAPITAL REDUCED CAPITAL RELATED COST 3	NEW CAPITAL CAPITAL RELATED COST 4	NEW CAPITAL SWING-BED ADJUSTMENT 5	NEW CAPITAL REDUCED CAPITAL RELATED COST 6	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				26715		26715	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL				26715		26715	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	OLD CAPITAL INPATIENT PROGRAM CAPITAL COST 10	NEW CAPITAL PER DIEM 11	NEW CAPITAL INPATIENT PROGRAM CAPITAL COST 12	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	552	6			48.40	290	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL	552	6				290	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
PART II

CHECK APPLICABLE BOXES								
	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB III	[XX]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SUB IV	[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	SUB II	[ ]	OTHER		

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	333161	3104856	16704				.107303	1792	37
40	ANESTHESIOLOGY			80541	1340					40
41	RADIOLOGY-DIAGNOSTIC			136790	1043					41
44	LABORATORY			144728	915					44
46	WHOLE BLOOD & PACKED RED BLOO			13577						46
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY			32620	2024					49
50	PHYSICAL THERAPY	1679	188954	1680				.008886	15	50
55	MEDICAL SUPPLIES CHARGED TO P			7401719	115063					55
56	DRUGS CHARGED TO PATIENTS			627796	5937					56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC			144						60
62	OBSERVATION BEDS (NON-DISTINC	1404	35503					.039546		62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL	336244	11767228	144706					1807	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					552		6		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					552		6		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES								
[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
		[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		1	1.01	2	2.01	2.02	2.03	3	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM								37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46	WHOLE BLOOD & PACKED RED BLOO								46
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY								49
50	PHYSICAL THERAPY								50
55	MEDICAL SUPPLIES CHARGED TO P								55
56	DRUGS CHARGED TO PATIENTS								56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL								101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES								
	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		3104856			16704			37
40	ANESTHESIOLOGY		80541			1340			40
41	RADIOLOGY-DIAGNOSTIC		136790			1043			41
44	LABORATORY		144728			915			44
46	WHOLE BLOOD & PACKED RED BLOO		13577						46
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		32620			2024			49
50	PHYSICAL THERAPY		188954			1680			50
55	MEDICAL SUPPLIES CHARGED TO P		7401719			115063			55
56	DRUGS CHARGED TO PATIENTS		627796			5937			56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC		144						60
62	OBSERVATION BEDS (NON-DISTINC		35503						62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		11767228			144706			101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (15-0167)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46	WHOLE BLOOD & PACKED RED BLOO						46
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
55	MEDICAL SUPPLIES CHARGED TO P						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
101	TOTAL						101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[ ]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[XX]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES: OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.340088	.340088	.340088				37
40	ANESTHESIOLOGY	.393799	.393799	.393799				40
41	RADIOLOGY-DIAGNOSTIC	.666935	.666935	.666935				41
44	LABORATORY	.351943	.351943	.351943				44
46	WHOLE BLOOD & PACKED RED BLOOD	.491714	.491714	.491714				46
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.652422	.652422	.652422				49
50	PHYSICAL THERAPY	.525313	.525313	.525313				50
55	MEDICAL SUPPLIES CHARGED TO PAT	.515093	.515093	.515093				55
56	DRUGS CHARGED TO PATIENTS	.394654	.394654	.394654				56
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	.361111	.361111	.361111				60
62	OBSERVATION BEDS (NON-DISTINCT	.721122	.721122	.721122				62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65.01	AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.							65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.394654	1
2	PROGRAM VACCINE CHARGES		2
2.01	PROGRAM VACCINE CHARGES		2.01
3	PROGRAM COSTS		3
3.01	PROGRAM COSTS		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES						
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[ ]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[XX]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES: ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES: ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST: OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST: OUTPATIENT RADIOLOGY 7	PROGRAM COST: OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	20378								37
40	ANESTHESIOLOGY	2680								40
41	RADIOLOGY-DIAGNOSTIC									41
44	LABORATORY	109								44
46	WHOLE BLOOD & PACKED RED BLOOD									46
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY	1894								49
50	PHYSICAL THERAPY									50
55	MEDICAL SUPPLIES CHARGED TO PA	27969								55
56	DRUGS CHARGED TO PATIENTS	2804								56
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC									63.50
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65.01	AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	55834								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	55834								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (15-0167)	[ ]	SNF
[ ]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[XX]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST: ALL OTHER (COLS 1x5) 9	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST: ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.03) 9.03	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.04) 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	6930							37
40	ANESTHESIOLOGY	1055							40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY	38							44
46	WHOLE BLOOD & PACKED RED BLOOD								46
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY	1236							49
50	PHYSICAL THERAPY								50
55	MEDICAL SUPPLIES CHARGED TO PAT	14407							55
56	DRUGS CHARGED TO PATIENTS	1107							56
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RHC								63.50
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65.01	AMBULANCE CHARGES (S-2 LINE 56.								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	24773							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	24773							104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	SNF	
	INPATIENT DAYS	1	1	1	1	1	1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	552						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	552						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	552						3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							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							6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	147						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							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							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							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	487318						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	487318						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	573575						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	573575						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO							31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE							33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	487318						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	882.82					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	129775					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	129775					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1141111					48
49	TOTAL PROGRAM INPATIENT COSTS	1270886					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	7115					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	48841					51
52	TOTAL PROGRAM EXCLUDABLE COST	55956					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	1214930					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

	SNF	
	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	29					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	882.82					84
85 OBSERVATION BED COST	25602					85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

		COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86	OLD CAPITAL-RELATED COST		487318		25602		86
87	NEW CAPITAL-RELATED COST	26715	487318	.054820	25602	1404	87
88	NON PHYSICIAN ANESTHETIST		487318		25602		88
89	MEDICAL EDUCATION		487318		25602		89

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	NF	
	INPATIENT DAYS	1	1	1	1	1	1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	552						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	552						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	552						3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							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							6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6						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							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							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							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	487318						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	487318						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	573575						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	573575						29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO							31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE							33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	487318						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	882.82					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5297					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	5297					41

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5	
42	NURSERY (TITLES V AND XIX ONLY)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	71042					48
49	TOTAL PROGRAM INPATIENT COSTS	76339					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	290					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	1807					51
52	TOTAL PROGRAM EXCLUDABLE COST	2097					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	74242					53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY NF

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

	HOSPITAL (PPS) (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	29					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	882.82					84
85 OBSERVATION BED COST	25602					85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

		COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86	OLD CAPITAL-RELATED COST		487318		25602		86
87	NEW CAPITAL-RELATED COST	26715	487318	.054820	25602	1404	87
88	NON PHYSICIAN ANESTHETIST		487318		25602		88
89	MEDICAL EDUCATION		487318		25602		89

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (15-0167) [ ] SNF [XX] PPS
[XX] TITLE XVIII-PT A [ ] SUB I [ ] NF [ ] TEFRA
[ ] TITLE XIX [ ] SUB II [ ] S/B-SNF [ ] OTHER
[ ] SUB III [ ] S/B-NF
[ ] SUB IV [ ] ICF/MR

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		170810		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.340088	450591	153241	37
40	ANESTHESIOLOGY	.393799	22970	9046	40
41	RADIOLOGY-DIAGNOSTIC	.666935	26484	17663	41
44	LABORATORY	.351943	38547	13566	44
46	WHOLE BLOOD & PACKED RED BLOOD	.491714	6694	3292	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.652422	11028	7195	49
50	PHYSICAL THERAPY	.525313	55286	29042	50
55	MEDICAL SUPPLIES CHARGED TO PAT	.515093	1488124	766522	55
56	DRUGS CHARGED TO PATIENTS	.394654	358522	141492	56
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	.361111	144	52	60
62	OBSERVATION BEDS (NON-DISTINCT	.721122			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.60	FQHC				63.60
101	TOTAL		2458390	1141111	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		2458390		103

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (15-0167) [ ] SNF [XX] PPS
[ ] TITLE XVIII-PT A [ ] SUB I [ ] NF [ ] TEFRA
[XX] TITLE XIX [ ] SUB II [ ] S/B-SNF [ ] OTHER
[ ] SUB III [ ] S/B-NF
[ ] SUB IV [ ] ICF/MR

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		7616		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.340088	16704	5681	37
40	ANESTHESIOLOGY	.393799	1340	528	40
41	RADIOLOGY-DIAGNOSTIC	.666935	1043	696	41
44	LABORATORY	.351943	915	322	44
46	WHOLE BLOOD & PACKED RED BLOOD	.491714			46
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.652422	2024	1321	49
50	PHYSICAL THERAPY	.525313	1680	883	50
55	MEDICAL SUPPLIES CHARGED TO PAT	.515093	115063	59268	55
56	DRUGS CHARGED TO PATIENTS	.394654	5937	2343	56
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	.361111			60
62	OBSERVATION BEDS (NON-DISTINCT	.721122			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.60	FQHC				63.60
101	TOTAL		144706	71042	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		144706		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	DRG AMOUNT						
1	OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	549456					1.01
1.02	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03	PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04	PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05	PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06	ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07	PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08	SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997	80833					2.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
3	BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD	23.02					3
3.01	NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06	ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]						3.06
3.07	SUM OF LINES 3.04-3.06	0.00	0.00				3.07
3.08	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13	FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14	CURRENT YEAR ALLOWABLE FTE						3.14
3.15	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
		RES. IN INIT YRS					
3.17	SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	0.00					3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
3.18	CURRENT YEAR RESIDENT TO BED RATIO						3.18
3.19	PRIOR YEAR RESIDENT TO BED RATIO						3.19
3.20	FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19						3.20
3.21	IME PAYMENTS FOR DSCHGS OCCURRING PRIOR TO OCTOBER 1						3.21
3.22	IME PAYMENTS FOR DSCHGS AFTER SEP 30 BUT BEFORE JAN 1						3.22
3.23	IME PAYMENTS FOR DSCHGS OCCURRING ON OR AFTER JANUARY 1 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23 0 0						3.24
	DISPROPORTIONATE SHARE ADJUSTMENT						
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS						4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS						4.01
4.02	SUM OF 4 AND 4.01						4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT						4.04
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317						5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302,						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs						5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						5.05
5.06	TOTAL ADDITIONAL PAYMENT						5.06
6	SUBTOTAL	630289					6
7	HOSPITAL SPECIFIC PAYMENTS						7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)						7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS	630289					8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL	54681					9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL						10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT						11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE						11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES						11.02
12	NET ORGAN ACQUISITION COST						12
13	COST OF TEACHING PHYSICIANS						13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS						14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						15
16	TOTAL	684970					16
17	PRIMARY PAYER PAYMENTS						17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	684970					18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	41277					19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES						20
21	REIMBURSABLE BAD DEBTS						21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS						21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						21.02
22	SUBTOTAL	643693					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						23
24	OTHER ADJUSTMENTS						24
25	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						25
26	AMOUNT DUE PROVIDER	643693					26
27	SEQUESTRATION ADJUSTMENT						27
28	INTERIM PAYMENTS	633390					28
28.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						28.01
29	BALANCE DUE PROVIDER (PROGRAM)	10303					29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						30
	TO BE COMPLETED BY INTERMEDIARY						
50	OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01						50
51	CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01						51
52	OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIO						52
53	CAPITAL OUTLIER RECONILIATION AMOUNT (SEE INSTRUCTIONS)						53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)						55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (15-0167) 1	HOSPITAL (15-0167) 1.01	HOSPITAL (15-0167) 1.02	
1	MEDICAL AND OTHER SERVICES				1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000	114791			1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS	77556			1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST				5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	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)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES				17
17.01	TOTAL PPS PAYMENTS	77556			17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (15-0167) 1	HOSPITAL (15-0167) 1.01	HOSPITAL (15-0167) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES AND COINSURANCE				18
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO LINE 17.01	16280			18.01
19	SUBTOTAL	61276			19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL	61276			23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL	61276			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS				27
27.01	REDUCED REIMBURSABLE BAD DEBTS				27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28	SUBTOTAL	61276			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL	61276			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	61276			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM				35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (15-0167) OCTOBER 1, 1997 PRIOR TO 1	ON OR AFTER 1.01	
1	STANDARD OVERHEAD AMOUNTS (ASC FEES)			1
2	DEDUCTIBLES			2
3	SUBTOTAL			3
4	80 PERCENT OF LINE 3			4
5	ASC PORTION OF BLEND			5
6	OUTPATIENT ASC COST			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	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)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	HOSPITAL SPECIFIC PORTION OF BLEND			17
18	ASC BLENDED AMOUNT			18
19	LESSER OF LINES 16 OR 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	ASC PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (15-0167) OCTOBER 1, 1997 PRIOR TO 1	ON OR AFTER 1.01	
1	PREVAILING CHARGES			1
2	62 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OUTPATIENT RADIOLOGY			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	RADIOLOGY PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V [XX] TITLE XVIII [ ] TITLE XIX

		HOSPITAL (15-0167) OCTOBER 1, 1997 PRIOR TO 1	ON OR AFTER 1.01	
1	PREVAILING CHARGES			1
2	42 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	DIAGNOSTIC PAYMENT AMOUNT			21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1
HOSPITAL (15-0167)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				624113		56721	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.				9277		4555	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
	PROGRAM	.02					3.02
	TO	.03		NONE		NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				633390		61276	4
	TO BE COMPLETED BY INTERMEDIARY						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02					5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51					5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____ DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY PART III

[ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

		HOSPITAL (15-0167) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES							1
2	MEDICAL AND OTHER SERVICES	24773						2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	24773						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	24773						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES	7616						10
11	ANCILLARY SERVICE CHARGES	200540						11
12	INTERNS AND RESIDENTS SERVICE CHARGES							12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE							13
14	TEACHING PHYSICIANS							14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION							15
16	TOTAL REASONABLE CHARGES	208156						16
	CUSTOMARY CHARGES							
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							18
19	RATIO OF LINE 17 TO LINE 18							19
20	TOTAL CUSTOMARY CHARGES	208156						20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	183383						21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							22
23	COST OF COVERED SERVICES	24773						23
	PROSPECTIVE PAYMENT AMOUNT							
24	OTHER THAN OUTLIER PAYMENTS							24
25	OUTLIER PAYMENTS							25
26	PROGRAM CAPITAL PAYMENTS							26
27	CAPITAL EXCEPTION PAYMENTS							27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS							28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS							29
30	SUBTOTAL	24773						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED	55834						31
32	LESSER OF LINES 30 OR 31	24773						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY PART III

[ ] TITLE V [ ] TITLE XVIII [XX] TITLE XIX

		HOSPITAL (15-0167) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST							34
35	SUBTOTAL	24773						35
36	COINSURANCE							36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,							37
38	REIMBURSABLE BAD DEBTS							38
38.01	REDUCED REIMBURSABLE BAD DEBTS							38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							38.02
39	UTILIZATION REVIEW							39
40	SUBTOTAL	24773						40
41	INPATIENT ROUTINE SERVICE COST							41
42	MEDICARE INPATIENT ROUTINE CHARGES							42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							44
45	RATIO OF LINE 43 TO LINE 44							45
46	TOTAL CUSTOMARY CHARGES							46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							49
50	OTHER ADJUSTMENTS							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL	24773						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	24773						55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS	26555						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM	-1782						58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							59

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2107711				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	6819754				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE					6
7	INVENTORY	12757				7
8	PREPAID EXPENSES	392662				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	9332884				11
	FIXED ASSETS					
12	LAND					12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS					13
13.01	ACCUMULATED DEPRECIATION					13.01
14	BUILDINGS					14
14.01	ACCUMULATED DEPRECIATION					14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT					16
16.01	ACCUMULATED DEPRECIATION					16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT	2414367				18
18.01	ACCUMULATED DEPRECIATION	-179490				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	2234877				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	50247366				25
26	TOTAL OTHER ASSETS	50247366				26
27	TOTAL ASSETS	61815127				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	4135205				28
29	SALARIES, WAGES & FEES PAYABLE					29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES					35
36	TOTAL CURRENT LIABILITIES	4135205				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	26042231				38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES	89603				41
42	TOTAL LONG TERM LIABILITIES	26131834				42
43	TOTAL LIABILITIES	30267039				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	31548088				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	31548088				51
52	TOTAL LIABILITIES AND FUND BALANCES	61815127				52

STATEMENT OF CHANGES IN FUND BALANCES WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (LOSS)	1264755				2
3	TOTAL	1264755				3
4	ADDITIONS (CREDIT ADJUSTMENTS)	30283333				4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS	30283333				10
11	SUBTOTAL	31548088				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	31548088				19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	586704		586704	1
2	SUBPROVIDER I				2
4	SWING BED - SNF				4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	586704		586704	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	586704		586704	16
17	ANCILLARY SERVICES	9428770		9428770	17
18	OUTPATIENT SERVICES		2861014	2861014	18
18.50	RHC				18.50
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	10015474	2861014	12876488	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		5634459	26
27	**ADD (SPECIFY)**			27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS			33
34	**DEDUCT (SPECIFY)** ROUNDING	-1		34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS	-1		39
40	TOTAL OPERATING EXPENSES		5634458	40

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	12876488	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	6110337	2
3	NET PATIENT REVENUES	6766151	3
4	LESS - TOTAL OPERATING EXPENSES	5634458	4
5	NET INCOME FROM SERVICE TO PATIENTS	1131693	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	17960	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (SPECIFY)		24
24.02	OTHER OPERATING INCOME	115102	24.02
25	TOTAL OTHER INCOME	133062	25
26	TOTAL	1264755	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1264755	31

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD WORKSHEET L

		HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV	
	PART I - FULLY PROSPECTIVE METHOD						
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS						1
	CAPITAL FEDERAL AMOUNT						
2	CAPITAL DRG OTHER THAN OUTLIER	46688					2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997						3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997	7993					3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [E,PT A,LN.3.17][x E-3,PT VI,LN.1] [E-3,PT VI,LN.18]						4
4.01	NO. OF INTERNS & RESIDENTS 0.00 0.00						4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						4.02
4.03	INDIRECT MEDICAL EDUCATON ADJUSTMENT						4.03
	DISPROPORTIONATE SHARE ADJUSTMENT						
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS						5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I						5.01
5.02	SUM OF LINES 5 AND 5.01						5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT						5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	54681					6
	PART II - HOLD HARMLESS METHOD						
1	NEW CAPITAL						1
2	OLD CAPITAL						2
3	TOTAL CAPITAL						3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL						4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE						5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT						6
7	REDUCED OLD CAPITAL AMOUNT						7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL						8
9	SUBTOTAL						9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)						10
	PART III - PAYMENT UNDER REASONABLE COST						
1	PROGRAM INPATIENT ROUTINE CAPITAL COST						1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST						2
3	TOTAL INPATIENT PROGRAM CAPITAL						3
4	CAPITAL COST PAYMENT FACTOR						4
5	TOTAL INPATIENT PROGRAM CAPITAL COST						5
	PART IV - COMPUTATION OF EXCEPTION PAYMENTS						
1	PROGRAM INPATIENT CAPITAL COSTS						1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						2
3	NET PROGRAM INPATIENT CAPITAL COSTS						3
4	APPLICABLE EXCEPTION PERCENTAGE						4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS						5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES						6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES						7
8	CAPITAL MINIMUM PAYMENT LEVEL						8
9	CURRENT YEAR CAPITAL PAYMENTS						9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS						10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT						11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS						12
13	CURRENT YEAR EXCEPTION PAYMENT						13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD						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						17

CALCULATION OF CAPITAL PAYMENT - TITLE XIX - COST METHOD WORKSHEET L

		HOSPITAL (15-0167)	SUB I	SUB II	SUB III	SUB IV
	PART I - FULLY PROSPECTIVE METHOD					
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS					1
	CAPITAL FEDERAL AMOUNT					
2	CAPITAL DRG OTHER THAN OUTLIER					2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997					3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997					3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT					
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD					4
4.01	NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I					4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE					4.02
4.03	INDIRECT MEDICAL EDUCATON ADJUSTMENT					4.03
	DISPROPORTIONATE SHARE ADJUSTMENT					
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS					5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I					5.01
5.02	SUM OF LINES 5 AND 5.01					5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE					5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT					5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS					6
	PART II - HOLD HARMLESS METHOD					
1	NEW CAPITAL					1
2	OLD CAPITAL					2
3	TOTAL CAPITAL					3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL					4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE					5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT					6
7	REDUCED OLD CAPITAL AMOUNT					7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL					8
9	SUBTOTAL					9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)					10
	PART III - PAYMENT UNDER REASONABLE COST					
1	PROGRAM INPATIENT ROUTINE CAPITAL COST					1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST					2
3	TOTAL INPATIENT PROGRAM CAPITAL					3
4	CAPITAL COST PAYMENT FACTOR					4
5	TOTAL INPATIENT PROGRAM CAPITAL COST					5
	PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1	PROGRAM INPATIENT CAPITAL COSTS					1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES					2
3	NET PROGRAM INPATIENT CAPITAL COSTS					3
4	APPLICABLE EXCEPTION PERCENTAGE					4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS					5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES					6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES					7
8	CAPITAL MINIMUM PAYMENT LEVEL					8
9	CURRENT YEAR CAPITAL PAYMENTS					9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS					10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT					11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS					12
13	CURRENT YEAR EXCEPTION PAYMENT					13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD					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					17

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

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS 0	SUBTOTAL 4A	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS						
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES A						22
23	I&R SERVICES-OTHER PRGM COSTS A						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46	WHOLE BLOOD & PACKED RED BLOOD						46
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
55	MEDICAL SUPPLIES CHARGED TO PAT						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
00	STUDENT NURSE PROGRAM						00
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

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

	COST CENTERS	---- TITLE XVIII ---- PART A 1	PART B 2	----- TITLE XIX ----- INPATIENT 3	OUTPATIENT 4	------ TITLE V ------ INPATIENT 5	OUTPATIENT 6	TOTAL THIRD PARTY 7	UTIL
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	26.63		1.09				27.72	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	14.51	3.79	0.54	0.66			19.50	37
40	ANESTHESIOLOGY	28.52	18.77	1.66	3.33			52.28	40
41	RADIOLOGY-DIAGNOSTIC	19.36	2.90	0.76				23.02	41
44	LABORATORY	26.63	1.15	0.63	0.08			28.49	44
46	WHOLE BLOOD & PACKED RED BLOOD	49.30	4.29					53.59	46
49	RESPIRATORY THERAPY	33.81	0.75	6.20	5.81			46.57	49
50	PHYSICAL THERAPY	29.26		0.89				30.15	50
55	MEDICAL SUPPLIES CHARGED TO PAT	20.11	0.85	1.55	0.38			22.89	55
56	DRUGS CHARGED TO PATIENTS	57.11	11.10	0.95	0.45			69.61	56
60	CLINIC	100.00						100.00	60
62	OBSERVATION BEDS (NON-DISTINCT		21.15					21.15	62
101	TOTAL CHARGES	19.92	2.26	1.17	0.45			23.80	101

	COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	32705	.55	-32705	-1.52			3
4	NEW CAP REL COSTS-MVBLE EQUIP	328850	5.55	-328850	-15.32			4
5	EMPLOYEE BENEFITS	174634	2.95	-174634	-8.13			5
6	ADMINISTRATIVE & GENERAL	1469788	24.83	-1469788	-68.46			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	57848	.98	-57848	-2.69			8
9	LAUNDRY & LINEN SERVICE							9
10	HOUSEKEEPING	33964	.57	-33964	-1.58			10
11	DIETARY	21681	.37	-21681	-1.01			11
12	CAFETERIA							12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION							14
15	CENTRAL SERVICES & SUPPLY	3299	.06	-3299	-.15			15
16	PHARMACY	1153	.02	-1153	-.05			16
17	MEDICAL RECORDS & LIBRARY	15642	.26	-15642	-.73			17
18	SOCIAL SERVICE	7297	.12	-7297	-.34			18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A							22
23	I&R SERVICES-OTHER PRGM COSTS A							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	196246	3.31	291072	13.56	487318	8.23	25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	324515	5.48	731410	34.07	1055925	17.84	37
40	ANESTHESIOLOGY	23755	.40	7962	.37	31717	.54	40
41	RADIOLOGY-DIAGNOSTIC	68329	1.15	22901	1.07	91230	1.54	41
44	LABORATORY	38150	.64	12786	.60	50936	.86	44
46	WHOLE BLOOD & PACKED RED BLOOD	5000	.08	1676	.08	6676	.11	46
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	15940	.27	5342	.25	21282	.36	49
50	PHYSICAL THERAPY	49814	.84	49446	2.30	99260	1.68	50
55	MEDICAL SUPPLIES CHARGED TO PAT	2855540	48.23	957036	44.58	3812576	64.40	55
56	DRUGS CHARGED TO PATIENTS	184416	3.12	63346	2.95	247762	4.19	56
60	CLINIC	39		13		52		60
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RHC							63.50
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40

	COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
100	STUDENT NURSE PROGRAM	11550	.20	3871	.18	15421	.26	100
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	5920155	100.00	0	.00	5920155	100.00	103

APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	TOTAL CHARGES 2	RATIO CAPITAL COST TO CHARGES 3	INPATIENT PROGRAM CHARGES 4	MEDICARE INPATIENT PPS CAPITAL COSTS 5	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	333161	3104856	.107303	450591	48350	37
40	ANESTHESIOLOGY		80541		22970		40
41	RADIOLOGY-DIAGNOSTIC		136790		26484		41
44	LABORATORY		144728		38547		44
46	WHOLE BLOOD & PACKED RED BLOOD		13577		6694		46
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
49	RESPIRATORY THERAPY		32620		11028		49
50	PHYSICAL THERAPY	1679	188954	.008886	55286	491	50
55	MEDICAL SUPPLIES CHARGED TO PAT		7401719		1488124		55
56	DRUGS CHARGED TO PATIENTS		627796		358522		56
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC		144		144		60
62	OBSERVATION BEDS (NON-DISTINCT	1404	35503	.039546			62
	OTHER REIMBURSABLE COST CENTERS						
63.50	RHC						63.50
63.60	FQHC						63.60
101	TOTAL	336244	11767228		2458390	48841	101

APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS 1	SWING-BED ADJUSTMENT AMOUNT 2	TOTAL COST 3	TOTAL PATIENT DAYS 4	PER DIEM 5	INPATIENT PROGRAM DAYS 6	MEDICARE INPATIENT PPS CAPITAL COSTS 7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
25	ADULTS & PEDIATRICS	26715		26715	552	48.40	147	7115	25
101	TOTAL	26715		26715			147	7115	101

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS		7115
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS		48841
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS		55956
MEDICARE DISCHARGES (WORKSHEET S-3, LINE 8, COLUMN 13)	53	
MEDICARE PATIENT DAYS (WORKSHEET S-3, LINE 8, COLUMN 4)	147	
PER DISCHARGE CAPITAL COSTS		1055.77
PER DIEM CAPITAL COSTS		380.65

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1.	TOTAL PROGRAM (TITLE XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (WORKSHEET D-1 PART II LINE 53)	1214930
2.	HOSPITAL PART A TITLE XVIII CHARGES (SUM OF INPATIENT CHARGES AND ANCILLARY CHARGES ON WKST D-4 FOR HOSPITAL TITLE XVIII COMPONENT)	2629200
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.462

II. COST TO CHARGE RATIO FOR CAPITAL

1.	TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (WKST D PART I LINES 25-30, COLS 10 & 12 + WKST D PART II, LINE 101, COLS 6 & 8)	55956
2.	RATIO OF COST TO CHARGES (LINE II-1 / LINE I-2)	.021

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	114791
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	279008
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.411