

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 05-30-2012 TIME: 08:55____
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY ORTHOPAEDIC HOSPT.AT PARKVIEW (15-0167) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 01/01/2011 AND ENDING 12/31/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		38,217	39,842			1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF						5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC						10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		38,217	39,842			200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 11119 PARKVIEW PLAZA DRIVE
 2 CITY: FORT WAYNE STATE: IN

P.O.BOX:
 ZIP CODE: 46845-1705 COUNTY: ALLEN

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

0	COMPONENT NAME	1	CCN NUMBER	2	CBSA NUMBER	3	PROV TYPE	4	DATE CERTIFIED	5	PAYMENT SYSTEM (P, T, O, OR N)		
											6	7	8
3	HOSPITAL	ORTHOPAEDIC HOSPT.AT PARKVIEW	15-0167	23060	1	11/08/2007	N	P	P	3	4	5	
4	SUBPROVIDER - IPF											6	
5	SUBPROVIDER - IRF											7	
6	SUBPROVIDER - (OTHER)											8	
7	SWING BEDS - SNF											9	
8	SWING BEDS - NF											10	
9	HOSPITAL-BASED SNF											11	
10	HOSPITAL-BASED NF											12	
11	HOSPITAL-BASED OLTC											13	
12	HOSPITAL-BASED HHA											14	
13	SEPARATELY CERTIFIED ASC											15	
14	HOSPITAL-BASED HOSPICE											16	
15	HOSPITAL-BASED HEALTH CLINIC - RHC											17	
16	HOSPITAL-BASED HEALTH CLINIC - FQHC											18	
17	HOSPITAL-BASED (CMHC)											19	
18	RENAL DIALYSIS											20	
19	OTHER											21	
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 01/01/2011										20	
21	TYPE OF CONTROL											21	

INPATIENT PPS INFORMATION

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

		IN-STATE MEDICAID PAID DAYS	1	IN-STATE MEDICAID ELIGIBLE DAYS	2	OUT-OF-STATE MEDICAID PAID DAYS	3	OUT-OF-STATE MEDICAID ELIGIBLE DAYS	4	MEDICAID HMO DAYS	5	OTHER MEDICAID DAYS	6
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.												25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.							1					26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.							1					27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.												35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							BEGINNING:		ENDING:			36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.												37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							BEGINNING:		ENDING:			38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	1	2	3
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/(COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 N 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&Rs IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	250,000	5,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	Y	15H032	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME: PARKVIEW HEALTH SYSTEM, INC. CONTRACTOR'S NAME: NATIONAL GOVERNMENT SERVICES	CONTRACTOR'S NUMBER: 8	141
142	STREET: 10501 CORPORATE DRIVE P.O. BOX: 5600		142
143	CITY: FORT WAYNE STATE: IN	ZIP CODE: 46895-5600	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	N	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	149

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

SEE 42 CFR §413.13)	PART A	PART B	
155 HOSPITAL	1	2	
156 SUBPROVIDER - IPF	N	N	155
157 SUBPROVIDER - IRF	N	N	156
158 SUBPROVIDER - (OTHER)	N	N	157
159 SNF	N	N	158
160 HHA	N	N	159
161 CMHC	N	N	160

MULTICAMPUS

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

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

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE	
PROVIDER ORGANIZATION AND OPERATION				
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1
		Y/N	DATE	V/I
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3
FINANCIAL DATA AND REPORTS				
		Y/N	TYPE	DATE
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 N	2	3 4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5
APPROVED EDUCATIONAL ACTIVITIES				
		Y/N	1	Y/N
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	2	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11
				Y/N
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14
BED COMPLEMENT				
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. 35

HOME OFFICE COSTS

- | | Y/N | DATE | |
|--|-----|------|--|
| | 1 | 2 | |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	5,159,697	6,437,599	11,597,296	364,974.00	31.78
2	NON-PHYSICIAN ANESTHETIST PART A						1
3	NON-PHYSICIAN ANESTHETIST PART B						2
4	PHYSICIAN-PART A						3
4.01	PHYSICIANS-PART A - DIRECT TEACHING						4
5	PHYSICIAN-PART B						4.01
6	NON-PHYSICIAN-PART B						5
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21					6
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)						7
8	HOME OFFICE PERSONNEL		3,188,078	3,188,078	79,869.00	39.92	7.01
9	SNF	44					8
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)			364	364	12.00	9
	OTHER WAGES & RELATED COSTS						10
11	CONTRACT LABOR (SEE INSTRUCTIONS)						11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES						12
13	CONTRACT LABOR: PHYSICIAN-PART A						13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS		3,188,078	3,188,078	79,869.00	39.92	14
15	HOME OFFICE: PHYSICIAN-PART A						15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						16
	WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)		5,462,331	5,462,331			17
18	WAGE-RELATED COSTS (OTHER)						18
19	EXCLUDED AREAS		171	171			19
20	NON-PHYSICIAN ANESTHETIST PART A						20
21	NON-PHYSICIAN ANESTHETIST PART B						21
22	PHYSICIAN PART A						22
23	PHYSICIAN PART B						23
24	WAGE-RELATED COSTS (RHC/FQHC)						24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)						25
	OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		683,492	-597,310	86,182	2,159.00	39.92
27	ADMINISTRATIVE & GENERAL		516,916	3,698,987	4,215,903	107,543.00	39.20
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)						28
29	MAINTENANCE & REPAIRS						29
30	OPERATION OF PLANT		109,574	417,476	527,050	19,421.00	27.14
31	LAUNDRY & LINEN SERVICE						31
32	HOUSEKEEPING			404,581	404,581	10,136.00	39.92
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)						33
34	DIETARY			218,632	218,632	5,477.00	39.92
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)						35
36	CAFETERIA						36
37	MAINTENANCE OF PERSONNEL						37
38	NURSING ADMINISTRATION						38
39	CENTRAL SERVICES AND SUPPLY			31,676	31,676	794.00	39.89
40	PHARMACY			6,633	6,633	166.00	39.96
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY			58,208	58,208	3,185.00	18.28
42	SOCIAL SERVICE						42
43	OTHER GENERAL SERVICE						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	5,159,697	3,249,521	8,409,218	285,105.00	29.50	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		364	364	12.00	30.33	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5,159,697	3,249,157	8,408,854	285,093.00	29.50	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)		3,188,078	3,188,078	79,869.00	39.92	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5,462,331		5,462,331		64.96%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	10,622,028	6,437,235	17,059,263	364,962.00	46.74	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	1,309,982	4,238,883	5,548,865	148,881.00	37.27	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED	
RETIREMENT COST		
1 401K EMPLOYER CONTRIBUTIONS		1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	342,875	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	1,031,105	3
4 PRIOR YEAR PENSION SERVICE COST		4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)		
5 401K/TSA PLAN ADMINISTRATION FEES		5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	42,424	7
HEALTH AND INSURANCE COST		
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	67,359	8
9 PRESCRIPTION DRUG PLAN		9
10 DENTAL, HEARING AND VISION PLAN		10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	24,267	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	54,144	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)		14
15 WORKERS' COMPENSATION INSURANCE	36,536	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)		16
TAXES		
17 FICA-EMPLOYERS PORTION ONLY	1,189,774	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19 UNEMPLOYMENT INSURANCE		19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES		20
OTHER		
21 EXECUTIVE DEFERRED COMPENSATION	30,628	21
22 DAY CARE COSTS AND ALLOWANCES		22
23 TUITION REIMBURSEMENT	30,401	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	2,849,513	24
PART B - OTHER THAN CORE RELATED COST		
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)		25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.309946	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				824,375	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				8,033,682	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				2,490,008	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,665,633	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,665,633	19
			UNINSURED PATIENTS	INSURED PATIENTS		TOTAL
			1	2		3
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY		11,827	161,774		173,601 20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)		3,666	50,141		53,807 21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE			4,449		4,449 22
23	COST OF CHARITY CARE		3,666	45,692		49,358 23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				503,790	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				51,250	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				452,540	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				140,263	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				189,621	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				1,855,254	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100					1
2	00200		1,832,547	1,832,547		2
3	00300				633,294	3
4	00400	683,492	1,699,032	2,382,524	-683,492	4
5	00500	516,916	8,111,062	8,627,978	-554,364	5
6	00600				1,626	6
7	00700	109,574	955,294	1,064,868	16,016	7
8	00800					8
9	00900		404,581	404,581		9
10	01000		218,632	218,632		10
11	01100					11
12	01200					12
13	01300					13
14	01400		42,582	42,582		14
15	01500		6,633	6,633		15
16	01600					16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,255,486	159,864	1,415,350	162,959	30
ANCILLARY SERVICE COST CENTERS						
50	05000	2,136,808	19,434,791	21,571,599	-17,292,960	50
53	05300				1,289,723	53
54	05400		234,500	234,500		54
60	06000		252,986	252,986		60
62	06200		98,150	98,150		62
62.30	06250					62.30
65	06500		83,059	83,059		65
65.01	03950					65.01
66	06600	396,657	10,013	406,670	60,512	66
71	07100				1,794,879	71
72	07200				14,562,164	72
73	07300	60,764	1,128,276	1,189,040	9,279	73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
90	09000		272	272		90
91	09100		144	144		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115	11500		1,188,583	1,188,583	364	115
118						118
		5,159,697	35,861,001	41,020,698		
NONREIMBURSABLE COST CENTERS						
200		5,159,697	35,861,001	41,020,698		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	1,832,547	83,631	1,916,178	1
2	00200	633,294	994,397	1,627,691	2
3	00300				3
4	00400	1,699,032	960,134	2,659,166	4
5	00500	8,073,614	926,313	8,999,927	5
6	00600	1,626		1,626	6
7	00700	1,080,884		1,080,884	7
8	00800				8
9	00900	404,581		404,581	9
10	01000	218,632		218,632	10
11	01100				11
12	01200				12
13	01300				13
14	01400	42,582		42,582	14
15	01500	6,633		6,633	15
16	01600		58,208	58,208	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,578,309		1,578,309	30
ANCILLARY SERVICE COST CENTERS					
50	05000	4,278,639		4,278,639	50
53	05300	1,289,723		1,289,723	53
54	05400	234,500		234,500	54
60	06000	252,986		252,986	60
62	06200	98,150		98,150	62
62.30	06250				62.30
65	06500	83,059		83,059	65
65.01	03950				65.01
66	06600	467,182		467,182	66
71	07100	1,794,879		1,794,879	71
72	07200	14,562,164		14,562,164	72
73	07300	1,198,319		1,198,319	73
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
90	09000	272		272	90
91	09100	144		144	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
115	11500	1,188,947		1,188,947	115
118		41,020,698	3,022,683	44,043,381	118
NONREIMBURSABLE COST CENTERS					
200		41,020,698	3,022,683	44,043,381	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
	1	2	3	4	5
1 BUILDING DEPRECIATON	A	CAP REL COSTS-MVBLE EQUIP	2		633,294 1
500 TOTAL RECLASSIFICATIONS					633,294 500
CODE LETTER - A					
1 MED AND IV SUPPLIES	B	MEDICAL SUPPLIES CHRGED TO PA	71		16,357,043 1
2					2
500 TOTAL RECLASSIFICATIONS					16,357,043 500
CODE LETTER - B					
1 TELEPHONE EXPENSE	C	MAINTENANCE & REPAIRS	6		1,626 1
2					2
3					3
4					4
500 TOTAL RECLASSIFICATIONS					1,626 500
CODE LETTER - C					
1 PTO PAID	D	ADMINISTRATIVE & GENERAL	5	11,422	1
2		OPERATION OF PLANT	7	2,369	2
3		ADULTS & PEDIATRICS	30	27,742	3
4		OPERATING ROOM	50	47,217	4
5		PHYSICAL THERAPY	66	8,765	5
6		DRUGS CHARGED TO PATIENTS	73	1,343	6
7		AMBULATORY SURGICAL CENTER (D	115	52	7
500 TOTAL RECLASSIFICATIONS				98,910	500
CODE LETTER - D					
1 PTO ACCRUAL	E	ADMINISTRATIVE & GENERAL	5	67,508	1
2		OPERATION OF PLANT	7	13,999	2
3		ADULTS & PEDIATRICS	30	163,963	3
4		OPERATING ROOM	50	279,062	4
5		PHYSICAL THERAPY	66	51,802	5
6		DRUGS CHARGED TO PATIENTS	73	7,936	6
7		AMBULATORY SURGICAL CENTER (D	115	312	7
500 TOTAL RECLASSIFICATIONS				584,582	500
CODE LETTER - E					
1 HOME OFFICE	F	ADMINISTRATIVE & GENERAL	5	3,129,870	1
2		MEDICAL RECORDS & LIBRARY	16	58,208	2
500 TOTAL RECLASSIFICATIONS				3,188,078	500
CODE LETTER - F					
1 PURCHASE SERVICES	H	EMPLOYEE BENEFITS	4	86,182	1
2		ADMINISTRATIVE & GENERAL	5	490,187	2
3		OPERATION OF PLANT	7	401,108	3
4		HOUSEKEEPING	9	404,581	4
5		DIETARY	10	218,632	5
6		CENTRAL SERVICES & SUPPLY	14	31,676	6
7		PHARMACY	15	6,633	7
8		ADULTS & PEDIATRICS	30	15,751	8
9		OPERATING ROOM	50	427,003	9
10		RADIOLOGY-DIAGNOSTIC	54	234,463	10
11		LABORATORY	60	252,986	11
12		RESPIRATORY THERAPY	65	83,059	12
13		PHYSICAL THERAPY	66	1,941	13
14		DRUGS CHARGED TO PATIENTS	73	594,911	14
15		CLINIC	90	272	15
16		EMERGENCY	91	136	16
500 TOTAL RECLASSIFICATIONS				3,249,521	500
CODE LETTER - H					
1 IMPLANTS	I	IMPL. DEV. CHARGED TO PATIENT	72		14,562,164 1
500 TOTAL RECLASSIFICATIONS					14,562,164 500
CODE LETTER - I					
1 ANESTHESIA	J	ANESTHESIOLOGY	53		1,289,723 1
500 TOTAL RECLASSIFICATIONS					1,289,723 500
CODE LETTER - J					
GRAND TOTAL (INCREASES)				7,121,091	32,843,850

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
1	1	6	7	8	9	10
1 BUILDING DEPRECIATON	A	ADMINISTRATIVE & GENERAL	5		633,294	9 1
500 TOTAL RECLASSIFICATIONS					633,294	500
CODE LETTER - A						
1 MED AND IV SUPPLIES	B	ADULTS & PEDIATRICS	30		28,727	1
2		OPERATING ROOM	50		16,328,316	2
500 TOTAL RECLASSIFICATIONS					16,357,043	500
CODE LETTER - B						
1 TELEPHONE EXPENSE	C	ADULTS & PEDIATRICS	30		19	1
2		OPERATION OF PLANT	7		352	2
3		OPERATING ROOM	50		1,200	3
4		PHYSICAL THERAPY	66		55	4
500 TOTAL RECLASSIFICATIONS					1,626	500
CODE LETTER - C						
1 PTO PAID	D	EMPLOYEE BENEFITS	4	98,910		1
2						2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS				98,910		500
CODE LETTER - D						
1 PTO ACCRUAL	E	EMPLOYEE BENEFITS	4	584,582		1
2						2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS				584,582		500
CODE LETTER - E						
1 HOME OFFICE	F	ADMINISTRATIVE & GENERAL	5		3,129,870	1
2		MEDICAL RECORDS & LIBRARY	16		58,208	2
500 TOTAL RECLASSIFICATIONS					3,188,078	500
CODE LETTER - F						
1 PURCHASE SERVICES	H	EMPLOYEE BENEFITS	4		86,182	1
2		ADMINISTRATIVE & GENERAL	5		490,187	2
3		OPERATION OF PLANT	7		401,108	3
4		HOUSEKEEPING	9		404,581	4
5		DIETARY	10		218,632	5
6		CENTRAL SERVICES & SUPPLY	14		31,676	6
7		PHARMACY	15		6,633	7
8		ADULTS & PEDIATRICS	30		15,751	8
9		OPERATING ROOM	50		427,003	9
10		RADIOLOGY-DIAGNOSTIC	54		234,463	10
11		LABORATORY	60		252,986	11
12		RESPIRATORY THERAPY	65		83,059	12
13		PHYSICAL THERAPY	66		1,941	13
14		DRUGS CHARGED TO PATIENTS	73		594,911	14
15		CLINIC	90		272	15
16		EMERGENCY	91		136	16
500 TOTAL RECLASSIFICATIONS					3,249,521	500
CODE LETTER - H						
1 IMPLANTS	I	MEDICAL SUPPLIES CHRGED TO PA	71		14,562,164	1
500 TOTAL RECLASSIFICATIONS					14,562,164	500
CODE LETTER - I						
1 ANESTHESIA	J	OPERATING ROOM	50		1,289,723	1
500 TOTAL RECLASSIFICATIONS					1,289,723	500
CODE LETTER - J						
GRAND TOTAL (DECREASES)				683,492	39,281,449	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES	16,321,105	1,903,742		1,903,742		18,224,847		3
4 BUILDING IMPROVEMENTS	1,259,603	8,646		8,646		1,268,249	32,485	4
5 FIXED EQUIPMENT	30,139	158,219		158,219	54,854	133,504		5
6 MOVABLE EQUIPMENT	5,454,450	1,058,991		1,058,991	131,125	6,382,316	1,653,145	6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	23,065,297	3,129,598		3,129,598	185,979	26,008,916	1,685,630	8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	23,065,297	3,129,598		3,129,598	185,979	26,008,916	1,685,630	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,832,547						1,832,547
2 CAP REL COSTS-MVBLE EQUIP							
3 TOTAL (SUM OF LINES 1-2)	1,832,547						1,832,547

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	19,493,096		19,493,096	0.752385				1
2 CAP REL COSTS-MVBLE EQUIP	6,515,820	100,526	6,415,294	0.247615				2
3 TOTAL (SUM OF LINES 1-2)	26,008,916	100,526	25,908,390	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,916,178						1,916,178
2 CAP REL COSTS-MVBLE EQUIP	1,627,691						1,627,691
3 TOTAL	3,543,869						3,543,869

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF 5
			COST CENTER 3	LINE NO. 4	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	3,130,822			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS					14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OTHER OPERATING REVENUE	B	-1,485	ADMINISTRATIVE & GENERAL	5	33
34 OTHER OPERATING REVENUE	B	-3,971	ADMINISTRATIVE & GENERAL	5	34
35 SELF INSURANCE OFFSET	A	-102,683	EMPLOYEE BENEFITS	4	35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		3,022,683			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1	2	CAP REL COSTS-MVBLE EQUIP	994,397		994,397	9 1
2	5	ADMINISTRATIVE & GENERAL	4,730,849	3,799,080	931,769	2
3	1	CAP REL COSTS-BLDG & FIXT	83,631		83,631	9 3
4	4	EMPLOYEE BENEFITS	1,062,817		1,062,817	4
4.01	16	MEDICAL RECORDS & LIBRARY	58,208		58,208	4.01
5		TOTALS (SUM OF LINES 1-4)	6,929,902	3,799,080	3,130,822	5
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				

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

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

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

----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----						
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
6	B		PARKVIEW HEALTH SYSTEM, INC	60.00		6
7	B		NORTHEAST ORTHOPAEDIC HOSPITAL	40.00		7
8						8
9						9
10						10

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

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/30/2012 08:55

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.		2	3	4	5	6	7	8	9
200		TOTAL							200

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/30/2012 08:55

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.		12	13	14	15	16	17	18
10	11							
200	TOTAL							200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,916,178	1,916,178				1
2 CAP REL COSTS-MVBLE EQUIP	1,627,691		1,627,691			2
4 EMPLOYEE BENEFITS	2,659,166			2,659,166		4
5 ADMINISTRATIVE & GENERAL	8,999,927		28,134	973,908	10,001,969	5
6 MAINTENANCE & REPAIRS	1,626				1,626	6
7 OPERATION OF PLANT	1,080,884		765,719	121,753	1,968,356	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	404,581		1,007	93,462	499,050	9
10 DIETARY	218,632		5,626	50,506	274,764	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	42,582			7,317	49,899	14
15 PHARMACY	6,633			1,532	8,165	15
16 MEDICAL RECORDS & LIBRARY	58,208			13,447	71,655	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	1,578,309	1,106,184	146,255	337,953	3,168,701	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,278,639	750,608	678,626	667,637	6,375,510	50
53 ANESTHESIOLOGY	1,289,723				1,289,723	53
54 RADIOLOGY-DIAGNOSTIC	234,500			54,163	288,663	54
60 LABORATORY	252,986			58,442	311,428	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	98,150				98,150	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	83,059			19,187	102,246	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	467,182	59,386	2,324	106,071	634,963	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,794,879				1,794,879	71
72 IMPL. DEV. CHARGED TO PATIENT	14,562,164				14,562,164	72
73 DRUGS CHARGED TO PATIENTS	1,198,319			153,610	1,351,929	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
90 OUTPATIENT SERVICE COST CENTERS CLINIC	272			63	335	90
91 EMERGENCY	144			31	175	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)	1,188,947			84	1,189,031	115
118 SUBTOTALS (SUM OF LINES 1-117)	44,043,381	1,916,178	1,627,691	2,659,166	44,043,381	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	44,043,381	1,916,178	1,627,691	2,659,166	44,043,381	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	10,001,969					5
6 MAINTENANCE & REPAIRS	478	2,104				6
7 OPERATION OF PLANT	578,338		2,546,694			7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	146,630			645,680		9
10 DIETARY	80,731				355,495	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY	14,661					14
15 PHARMACY	2,399					15
16 MEDICAL RECORDS & LIBRARY	21,054					16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	931,021	1,215	1,470,172	372,742	355,495	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,873,240	824	997,595	252,927		50
53 ANESTHESIOLOGY	378,944					53
54 RADIOLOGY-DIAGNOSTIC	84,814					54
60 LABORATORY	91,503					60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	28,838					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	30,042					65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	186,564	65	78,927	20,011		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	527,368					71
72 IMPL. DEV. CHARGED TO PATIENT	4,278,615					72
73 DRUGS CHARGED TO PATIENTS	397,221					73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	98					90
91 EMERGENCY	51					91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)	349,359					115
118 SUBTOTALS (SUM OF LINES 1-117)	10,001,969	2,104	2,546,694	645,680	355,495	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	10,001,969	2,104	2,546,694	645,680	355,495	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY	64,560				14
15 PHARMACY		10,564			15
16 MEDICAL RECORDS & LIBRARY			92,709		16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS			92,709	6,392,055	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM				9,500,096	50
53 ANESTHESIOLOGY				1,668,667	53
54 RADIOLOGY-DIAGNOSTIC				373,477	54
60 LABORATORY				402,931	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				126,988	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY				132,288	65
65.01 WOUND CARE					65.01
66 PHYSICAL THERAPY				920,530	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	646			2,322,893	71
72 IMPL. DEV. CHARGED TO PATIENT	63,914			18,904,693	72
73 DRUGS CHARGED TO PATIENTS		10,564		1,759,714	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC				433	90
91 EMERGENCY				226	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
115 AMBULATORY SURGICAL CENTER (D.P.)				1,538,390	115
118 SUBTOTALS (SUM OF LINES 1-117)	64,560	10,564	92,709	44,043,381	118
NONREIMBURSABLE COST CENTERS					
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	64,560	10,564	92,709	44,043,381	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	6,392,055	30
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	9,500,096	50
53	ANESTHESIOLOGY	1,668,667	53
54	RADIOLOGY-DIAGNOSTIC	373,477	54
60	LABORATORY	402,931	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	126,988	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	132,288	65
65.01	WOUND CARE		65.01
66	PHYSICAL THERAPY	920,530	66
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	2,322,893	71
72	IMPL. DEV. CHARGED TO PATIENT	18,904,693	72
73	DRUGS CHARGED TO PATIENTS	1,759,714	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
90	CLINIC	433	90
91	EMERGENCY	226	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
115	AMBULATORY SURGICAL CENTER (D.P.)	1,538,390	115
118	SUBTOTALS (SUM OF LINES 1-117)	44,043,381	118
NONREIMBURSABLE COST CENTERS			
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	44,043,381	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL			28,134	28,134	28,134	5
6 MAINTENANCE & REPAIRS					1	6
7 OPERATION OF PLANT			765,719	765,719	1,626	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING			1,007	1,007	412	9
10 DIETARY			5,626	5,626	227	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY					41	14
15 PHARMACY					7	15
16 MEDICAL RECORDS & LIBRARY					59	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS		1,106,184	146,255	1,252,439	2,617	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		750,608	678,626	1,429,234	5,266	50
53 ANESTHESIOLOGY					1,065	53
54 RADIOLOGY-DIAGNOSTIC					238	54
60 LABORATORY					257	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					81	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY					84	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY		59,386	2,324	61,710	524	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					1,483	71
72 IMPL. DEV. CHARGED TO PATIENT					12,047	72
73 DRUGS CHARGED TO PATIENTS					1,117	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)					982	115
118 SUBTOTALS (SUM OF LINES 1-117)		1,916,178	1,627,691	3,543,869	28,134	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,916,178	1,627,691	3,543,869	28,134	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS 6	OPERATION OF PLANT 7	HOUSE- KEEPING 9	DIETARY 10	CENTRAL SERVICES & SUPPLY 14	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS	1					6
7 OPERATION OF PLANT		767,345				7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING			1,419			9
10 DIETARY				5,853		10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY					41	14
15 PHARMACY						15
16 MEDICAL RECORDS & LIBRARY						16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1	442,977	819	5,853		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		300,586	556			50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY						65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY		23,782	44			66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT					41	72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)						115
118 SUBTOTALS (SUM OF LINES 1-117)	1	767,345	1,419	5,853	41	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1	767,345	1,419	5,853	41	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	7					15
16 MEDICAL RECORDS & LIBRARY		59				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS		59	1,704,765		1,704,765	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			1,735,642		1,735,642	50
53 ANESTHESIOLOGY			1,065		1,065	53
54 RADIOLOGY-DIAGNOSTIC			238		238	54
60 LABORATORY			257		257	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			81		81	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			84		84	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY			86,060		86,060	66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,483		1,483	71
72 IMPL. DEV. CHARGED TO PATIENT			12,088		12,088	72
73 DRUGS CHARGED TO PATIENTS	7		1,124		1,124	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)			982		982	115
118 SUBTOTALS (SUM OF LINES 1-117)	7	59	3,543,869		3,543,869	118
NONREIMBURSABLE COST CENTERS						
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	7	59	3,543,869		3,543,869	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	ADMINIS-TRATIVE & GENERAL ACCUM COST 5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	38,655					1
2 CAP REL COSTS-MVBLE EQUIP		1,348,485				2
4 EMPLOYEE BENEFITS			11,511,114			4
5 ADMINISTRATIVE & GENERAL		23,308	4,215,903	-10,001,969	34,041,412	5
6 MAINTENANCE & REPAIRS					1,626	6
7 OPERATION OF PLANT		634,372	527,050		1,968,356	7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING		834	404,581		499,050	9
10 DIETARY		4,661	218,632		274,764	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY			31,676		49,899	14
15 PHARMACY			6,633		8,165	15
16 MEDICAL RECORDS & LIBRARY			58,208		71,655	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	22,315	121,167	1,462,942		3,168,701	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	15,142	562,218	2,890,090		6,375,510	50
53 ANESTHESIOLOGY					1,289,723	53
54 RADIOLOGY-DIAGNOSTIC			234,463		288,663	54
60 LABORATORY			252,986		311,428	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					98,150	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY			83,059		102,246	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	1,198	1,925	459,165		634,963	66
71 MEDICAL SUPPLIES CHRGED TO PATIENTS					1,794,879	71
72 IMPL. DEV. CHARGED TO PATIENT					14,562,164	72
73 DRUGS CHARGED TO PATIENTS			664,954		1,351,929	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC			272		335	90
91 EMERGENCY			136		175	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS						
115 AMBULATORY SURGICAL CENTER (D.P.)			364		1,189,031	115
118 SUBTOTALS (SUM OF LINES 1-117)	38,655	1,348,485	11,511,114	-10,001,969	34,041,412	118
NONREIMBURSABLE COST CENTERS						
CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,916,178	1,627,691	2,659,166		10,001,969	202
203 UNIT COST MULT-WS B PT I	49.571284	1.207052	0.231009		0.293818	203
204 COST TO BE ALLOC PER B PT II					28,134	204
205 UNIT COST MULT-WS B PT II					0.000826	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	HOUSE- KEEPING	DIETARY	CENTRAL SERVICES & SUPPLY
	SQUARE FEET 6	SQUARE FEET 7	SQUARE FEET 9	MEALS SERVED 10	COSTED REQUIS. 14
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS	38,655				6
7 OPERATION OF PLANT		38,655			7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING			38,655		9
10 DIETARY				13,510	10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					10,000
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	22,315	22,315	22,315	13,510	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	15,142	15,142	15,142		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY					65
65.01 WOUND CARE					65.01
66 PHYSICAL THERAPY	1,198	1,198	1,198		66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					100
72 IMPL. DEV. CHARGED TO PATIENT					9,900
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
115 AMBULATORY SURGICAL CENTER (D.P.)					115
118 SUBTOTALS (SUM OF LINES 1-117)	38,655	38,655	38,655	13,510	10,000
NONREIMBURSABLE COST CENTERS					
CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	2,104	2,546,694	645,680	355,495	64,560
203 UNIT COST MULT-WS B PT I	0.054430	65,882654	16,703661	26,313472	6,456000
204 COST TO BE ALLOC PER B PT II	1	767,345	1,419	5,853	41
205 UNIT COST MULT-WS B PT II	0.000026	19,851119	0,036709	0,433235	0,004100

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PHARMACY	MEDICAL	
	COSTED REQUIS. 15	RECORDS & LIBRARY TIME SPENT 16	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
8 LAUNDRY & LINEN SERVICE			8
9 HOUSEKEEPING			9
10 DIETARY			10
11 CAFETERIA			11
12 MAINTENANCE OF PERSONNEL			12
13 NURSING ADMINISTRATION			13
14 CENTRAL SERVICES & SUPPLY			14
15 PHARMACY	10,000		15
16 MEDICAL RECORDS & LIBRARY		10,000	16
17 SOCIAL SERVICE			17
19 NONPHYSICIAN ANESTHETISTS			19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
30 ADULTS & PEDIATRICS		10,000	30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
53 ANESTHESIOLOGY			53
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
65 RESPIRATORY THERAPY			65
65.01 WOUND CARE			65.01
66 PHYSICAL THERAPY			66
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS	10,000		73
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
90 CLINIC			90
91 EMERGENCY			91
92 OBSERVATION BEDS			92
OTHER REIMBURSABLE COST CENTERS			
SPECIAL PURPOSE COST CENTERS			
115 AMBULATORY SURGICAL CENTER (D.P.)			115
118 SUBTOTALS (SUM OF LINES 1-117)	10,000	10,000	118
NONREIMBURSABLE COST CENTERS			
200 CROSS FOOT ADJUSTMENTS			200
201 NEGATIVE COST CENTER			201
202 COST TO BE ALLOC PER B PT I	10,564	92,709	202
203 UNIT COST MULT-WS B PT I	1.056400	9.270900	203
204 COST TO BE ALLOC PER B PT II	7	59	204
205 UNIT COST MULT-WS B PT II	0.000700	0.005900	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST	THERAPY	TOTAL	RCE	TOTAL	
	(FROM WKST B, PART I, COL 26)	LIMIT ADJUSTMENT	COSTS	DISALLOWANCE	COSTS	
	1	2	3	4	5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,392,055		6,392,055		6,392,055	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	9,500,096		9,500,096		9,500,096	50
53 ANESTHESIOLOGY	1,668,667		1,668,667		1,668,667	53
54 RADIOLOGY-DIAGNOSTIC	373,477		373,477		373,477	54
60 LABORATORY	402,931		402,931		402,931	60
62 WHOLE BLOOD & PACKED RED BL	126,988		126,988		126,988	62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	132,288		132,288		132,288	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	920,530		920,530		920,530	66
71 MEDICAL SUPPLIES CHRGED TO	2,322,893		2,322,893		2,322,893	71
72 IMPL. DEV. CHARGED TO PATIE	18,904,693		18,904,693		18,904,693	72
73 DRUGS CHARGED TO PATIENTS	1,759,714		1,759,714		1,759,714	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	433		433		433	90
91 EMERGENCY	226		226		226	91
92 OBSERVATION BEDS	306,319		306,319		306,319	92
OTHER REIMBURSABLE COST CENTERS						
115 AMBULATORY SURGICAL CENTER	1,538,390		1,538,390		1,538,390	115
200 SUBTOTAL (SEE INSTRUCTIONS)	44,349,700		44,349,700		44,349,700	200
201 LESS OBSERVATION BEDS	306,319		306,319		306,319	201
202 TOTAL (SEE INSTRUCTIONS)	44,043,381		44,043,381		44,043,381	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,706,672		5,706,672			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	29,124,425	13,720,575	42,845,000	0.221732	0.221732	50
53 ANESTHESIOLOGY	792,255	2,243,655	3,035,910	0.549643	0.549643	53
54 RADIOLOGY-DIAGNOSTIC	741,268	450,964	1,192,232	0.313259	0.313259	54
60 LABORATORY	993,434	261,250	1,254,684	0.321141	0.321141	60
62 WHOLE BLOOD & PACKED RED BL	173,574	1,467	175,041	0.725476	0.725476	62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	213,873	73,742	287,615	0.459948	0.459948	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	2,316,955	17,741	2,334,696	0.394283	0.394283	66
71 MEDICAL SUPPLIES CHRGED TO	6,494,324	2,744,657	9,238,981	0.251423	0.251423	71
72 IMPL. DEV. CHARGED TO PATIE	63,973,392	6,996,586	70,969,978	0.266376	0.266376	72
73 DRUGS CHARGED TO PATIENTS	4,626,258	1,175,886	5,802,144	0.303287	0.303287	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC	467	187	654	0.662080	0.662080	90
91 EMERGENCY	153	1,078	1,231	0.183591	0.183591	91
92 OBSERVATION BEDS		243,748	243,748	1.256704	1.256704	92
OTHER REIMBURSABLE COST CENTERS						
115 AMBULATORY SURGICAL CENTER						115
200 SUBTOTAL (SEE INSTRUCTIONS)	115,157,050	27,931,536	143,088,586			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	115,157,050	27,931,536	143,088,586			202

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSP.T.AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,704,765		1,704,765	4,403	387.18	1,531	592,773	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,704,765		1,704,765	4,403		1,531	592,773	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX [] IRF

COST CENTER DESCRIPTION	CAP-REL	TOTAL	RATIO OF	INPATIENT	CAPITAL	
	COST	CHARGES	COST TO			
	(FROM WKST	(FROM WKST	CHARGES	PROGRAM	(COL.3 x	
	B, PT. II,	C, PT. I,	(COL.1 +	CHARGES	COL.4)	
	COL. 26)	COL. 8)	COL.2)		5	
	1	2	3	4		
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,735,642	42,845,000	0.040510	9,850,334	399,037	50
53 ANESTHESIOLOGY	1,065	3,035,910	0.000351	693,555	243	53
54 RADIOLOGY-DIAGNOSTIC	238	1,192,232	0.000200	341,096	68	54
60 LABORATORY	257	1,254,684	0.000205	385,043	79	60
62 WHOLE BLOOD & PACKED RED BLOO	81	175,041	0.000463	74,683	35	62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	84	287,615	0.000292	74,468	22	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	86,060	2,334,696	0.036861	808,627	29,807	66
71 MEDICAL SUPPLIES CHRGD TO PA	1,483	9,238,981	0.000161	2,260,602	364	71
72 IMPL. DEV. CHARGED TO PATIENT	12,088	70,969,978	0.000170	20,789,572	3,534	72
73 DRUGS CHARGED TO PATIENTS	1,124	5,802,144	0.000194	1,616,845	314	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		654		654		90
91 EMERGENCY		1,231		1,231		91
92 OBSERVATION BEDS	81,696	243,748	0.335166			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	1,919,818	137,381,914	137,381,914	36,894,825	433,503	200

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSP.T AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

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

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	4,403		1,531	30
31 INTENSIVE CARE UNIT				31
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	4,403		1,531	200

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-0167)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS		
APPLICABLE	[XX] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA		
BOXES	[] TITLE XIX	[] IRF	[] NF				
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)
	7	8	9	10	11	12	13
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	42,845,000		9,850,334		1,482,824	50
53	ANESTHESIOLOGY	3,035,910		693,555		115,335	53
54	RADIOLOGY-DIAGNOSTIC	1,192,232		341,096		67,689	54
60	LABORATORY	1,254,684		385,043		1,374	60
62	WHOLE BLOOD & PACKED RED BLO	175,041		74,683			62
62.30	BLOOD CLOTTING FOR HEMOPHILI						62.30
65	RESPIRATORY THERAPY	287,615		74,468		5,700	65
65.01	WOUND CARE						65.01
66	PHYSICAL THERAPY	2,334,696		808,627			66
71	MEDICAL SUPPLIES CHRGD TO P	9,238,981		2,260,602		346,543	71
72	IMPL. DEV. CHARGED TO PATIEN	70,969,978		20,789,572		791,247	72
73	DRUGS CHARGED TO PATIENTS	5,802,144		1,616,845		113,372	73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
90	CLINIC	654					90
91	EMERGENCY	1,231				1,078	91
92	OBSERVATION BEDS	243,748				26,259	92
OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	137,381,914		36,894,825		2,951,421	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCS NOT	COST SERVICES	COST SVCS NOT	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.221732	1,482,824			328,790		50
53 ANESTHESIOLOGY	0.549643	115,335			63,393		53
54 RADIOLOGY-DIAGNOSTIC	0.313259	67,689			21,204		54
60 LABORATORY	0.321141	1,374			441		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.725476						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.459948	5,700			2,622		65
65.01 WOUND CARE							65.01
66 PHYSICAL THERAPY	0.394283						66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.251423	346,543			87,129		71
72 IMPL. DEV. CHARGED TO PATIENT	0.266376	791,247			210,769		72
73 DRUGS CHARGED TO PATIENTS	0.303287	113,372			34,384		73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.662080						90
91 EMERGENCY	0.183591	1,078			198		91
92 OBSERVATION BEDS	1.256704	26,259			33,000		92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)		2,951,421			781,930		200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)		2,951,421			781,930		202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

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

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)		(COL.3 ÷ COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
INPAT ROUTINE SERV COST CTRS								
30 ADULTS & PEDIATRICS	1,704,765		1,704,765	4,403	387.18	72	27,877	30
31 INTENSIVE CARE UNIT								31
32 CORONARY CARE UNIT								32
33 BURN INTENSIVE CARE UNIT								33
34 SURGICAL INTENSIVE CARE UNIT								34
35 OTHER SPECIAL CARE (SPECIFY)								35
40 SUBPROVIDER - IPF								40
41 SUBPROVIDER - IRF								41
42 SUBPROVIDER I								42
43 NURSERY								43
44 SKILLED NURSING FACILITY								44
45 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	1,704,765		1,704,765	4,403		72	27,877	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] OTHER

COST CENTER DESCRIPTION	CAP-REL COST	TOTAL CHARGES	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
	(FROM WKST B, PT. II, COL. 26) 1	(FROM WKST C, PT. I, COL. 8) 2	(COL.1 ÷ COL.2) 3			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,735,642	42,845,000	0.040510	564,795	22,880	50
53 ANESTHESIOLOGY	1,065	3,035,910	0.000351	47,020	17	53
54 RADIOLOGY-DIAGNOSTIC	238	1,192,232	0.000200	13,181	3	54
60 LABORATORY	257	1,254,684	0.000205	37,243	8	60
62 WHOLE BLOOD & PACKED RED BLOO	81	175,041	0.000463	3,300	2	62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY	84	287,615	0.000292	3,600	1	65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY	86,060	2,334,696	0.036861	40,518	1,494	66
71 MEDICAL SUPPLIES CHRGD TO PA	1,483	9,238,981	0.000161	135,540	22	71
72 IMPL. DEV. CHARGED TO PATIENT	12,088	70,969,978	0.000170	1,519,075	258	72
73 DRUGS CHARGED TO PATIENTS	1,124	5,802,144	0.000194	90,294	18	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC		654	654	187		90
91 EMERGENCY		1,231	1,231			91
92 OBSERVATION BEDS	81,696	243,748	0.335166			92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	1,919,818	137,381,914	137,381,914	2,454,753	24,703	200

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSP.T.AT PARKVIEW
PERIOD FROM 01/01/2011 TO 12/31/2011

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/30/2012 08:55

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

COST CENTER DESCRIPTION	TOTAL	PER DIEM	INPATIENT	INPAT PGM
	PATIENT	COL.5 ÷	PROGRAM	PASS THRU
	DAYS	COL.6)	DAYS	COSTS
	6	7	8	(COL.7 x
				COL.8)
				9
INPAT ROUTINE SERV COST CTRS				
30 ADULTS & PEDIATRICS	4,403		72	30
31 INTENSIVE CARE UNIT				31
32 CORONARY CARE UNIT				32
33 BURN INTENSIVE CARE UNIT				33
34 SURGICAL INTENSIVE CARE UNIT				34
35 OTHER SPECIAL CARE (SPECIFY)				35
40 SUBPROVIDER - IPF				40
41 SUBPROVIDER - IRF				41
42 SUBPROVIDER I				42
43 NURSERY				43
44 SKILLED NURSING FACILITY				44
45 NURSING FACILITY				45
200 TOTAL (SUM OF LINES 30-199)	4,403		72	200

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPITAL AT PARKVIEW
 PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
 05/30/2012 08:55

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN ANESTHETIST COST 1					
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
65.01 WOUND CARE						65.01
66 PHYSICAL THERAPY						66
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[] TITLE V	[XX] HOSPITAL (15-0167)	[] SUB (OTHER)	[] ICF/MR	[XX] PPS
APPLICABLE	[] TITLE XVIII-PT A	[] IPF	[] SNF		[] TEFRA
BOXES	[XX] TITLE XIX	[] IRF	[] NF		[] OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PGM PASS-THRU COSTS	O/P PGM PASS-THRU COSTS
	(FROM WKST C, PT. I, COL. 8)	(COL. 5 + COL. 7)	(COL. 6 + COL. 7)	INPAT PGM CHARGES COL. 10	(COL. 8 x COL. 10) O/P PGM CHARGES COL. 12 (COL. 9 x COL. 12)
	7	8	9	10	11 12 13
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	42,845,000			564,795	50
53 ANESTHESIOLOGY	3,035,910			47,020	53
54 RADIOLOGY-DIAGNOSTIC	1,192,232			13,181	54
60 LABORATORY	1,254,684			37,243	60
62 WHOLE BLOOD & PACKED RED BLO	175,041			3,300	62
62.30 BLOOD CLOTTING FOR HEMOPHILI					62.30
65 RESPIRATORY THERAPY	287,615			3,600	65
65.01 WOUND CARE					65.01
66 PHYSICAL THERAPY	2,334,696			40,518	66
71 MEDICAL SUPPLIES CHRGD TO P	9,238,981			135,540	71
72 IMPL. DEV. CHARGED TO PATIEN	70,969,978			1,519,075	72
73 DRUGS CHARGED TO PATIENTS	5,802,144			90,294	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	654			187	90
91 EMERGENCY	1,231				91
92 OBSERVATION BEDS	243,748				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-199)	137,381,914			2,454,753	200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB.	COST REIMB.	COST	COST	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS	SERVICES SUBJECT TO DED & COINS	SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.221732		498,220			110,471	50
53 ANESTHESIOLOGY	0.549643		42,555			23,390	53
54 RADIOLOGY-DIAGNOSTIC	0.313259		21,108			6,612	54
60 LABORATORY	0.321141		16,780			5,389	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.725476		733			532	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.459948		4,798			2,207	65
65.01 WOUND CARE							65.01
66 PHYSICAL THERAPY	0.394283		1,175			463	66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.251423		107,984			27,150	71
72 IMPL. DEV. CHARGED TO PATIENT	0.266376		471,057			125,478	72
73 DRUGS CHARGED TO PATIENTS	0.303287		51,750			15,695	73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
90 CLINIC	0.662080						90
91 EMERGENCY	0.183591						91
92 OBSERVATION BEDS	1.256704		30,362			38,156	92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)			1,246,522			355,543	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			1,246,522			355,543	202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,403	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,403	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,403	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,531	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,392,055	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,392,055	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,689,302	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,689,302	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.123522	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,292.14	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,392,055	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,451,75 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,222,629 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,222,629 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					9,799,684	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					12,022,313	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 592,773 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 433,503 51
 52 TOTAL PROGRAM EXCLUDABLE COST 1,026,276 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 10,996,037 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 211 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,451,75 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 306,319 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	1,704,765	6,392,055	0.266701	306,319	81,696	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,403	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,403	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,403	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	72	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	6,392,055	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	6,392,055	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,689,302	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,689,302	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.123522	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	1,292.14	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	6,392,055	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (15-0167) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,451.75 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 104,526 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 104,526 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					653,424	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					757,950	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 27,877 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 24,703 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52,580 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 705,370 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 211 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
30 INPATIENT ROUTINE SERVICE COST CENTERS					
ADULTS & PEDIATRICS		2,075,261			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.221732	9,850,334	2,184,134		50
53 ANESTHESIOLOGY	0.549643	693,555	381,208		53
54 RADIOLOGY-DIAGNOSTIC	0.313259	341,096	106,851		54
60 LABORATORY	0.321141	385,043	123,653		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.725476	74,683	54,181		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.459948	74,468	34,251		65
65.01 WOUND CARE					65.01
66 PHYSICAL THERAPY	0.394283	808,627	318,828		66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.251423	2,260,602	568,367		71
72 IMPL. DEV. CHARGED TO PATIENT	0.266376	20,789,572	5,537,843		72
73 DRUGS CHARGED TO PATIENTS	0.303287	1,616,845	490,368		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC	0.662080				90
91 EMERGENCY	0.183591				91
92 OBSERVATION BEDS	1.256704				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		36,894,825	9,799,684		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		36,894,825			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SUB (OTHER) [] S/B SNF [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		99,024		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.221732	564,795	125,233	50
53 ANESTHESIOLOGY	0.549643	47,020	25,844	53
54 RADIOLOGY-DIAGNOSTIC	0.313259	13,181	4,129	54
60 LABORATORY	0.321141	37,243	11,960	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.725476	3,300	2,394	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.459948	3,600	1,656	65
65.01 WOUND CARE				65.01
66 PHYSICAL THERAPY	0.394283	40,518	15,976	66
71 MEDICAL SUPPLIES CHRGD TO PATI	0.251423	135,540	34,078	71
72 IMPL. DEV. CHARGED TO PATIENT	0.266376	1,519,075	404,645	72
73 DRUGS CHARGED TO PATIENTS	0.303287	90,294	27,385	73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
90 CLINIC	0.662080	187	124	90
91 EMERGENCY	0.183591			91
92 OBSERVATION BEDS	1.256704			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		2,454,753	653,424	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		2,454,753		202

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0167)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	7,061,320	1
2	OUTLIER PAYMENTS FOR DISCHARGES (SEE INSTRUCTIONS)	316,514	2
3	MANAGED CARE SIMULATED PAYMENTS	3,982,670	3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	35.42	4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS		
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (SEE INSTRUCTIONS)		5
6	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH 42 CFR 413.79(e)		6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(1)		7
7.01	ACA SECTION 5503 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105 (f)(1)(iv)(B)(2). IF THE COST REPORT STRADDLES JULY 1, 2011 THEN SEE INSTRUCTIONS.		7.01
8	ADJUSTMENT (INCREASE OR DECREASE) TO THE FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH 42 CFR §413.75(b), §413.79(c)(2) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 50069, AUGUST 1, 2002.		8
8.01	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS UNDER SECTION 5503 OF THE ACA. IF THE COST REPORT STRADDLES JULY 1, 2011, SEE INSTRUCTIONS.		8.01
8.02	THE AMOUNT OF INCREASE IF THE HOSPITAL WAS AWARDED FTE CAP SLOTS FROM A CLOSED TEACHING HOSPITAL UNDER SECTION 5506 OF ACA. (SEE INSTRUCTIONS)		8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (SEE INSTRUCTIONS)		9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS		11
12	CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR	0.51	13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO		14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3	0.17	15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM		16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE		17
18	ADJUSTED ROLLING AVERAGE FTE COUNT	0.17	18
19	CURRENT YEAR RESIDENT TO BED RATIO (LINE 18 DIVIDED BY LINE 4)	0.004800	19
20	PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)	0.009954	20
21	ENTER THE LESSER OF LINES 19 OR 20 (SEE INSTRUCTIONS)	0.004800	21
22	IME PAYMENT ADJUSTMENT (SEE INSTRUCTIONS)	28,935	22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON		
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)		23
24	IME FTE RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)		24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (SEE INSTRUCTIONS)		25
26	RESIDENT TO BED RATIO (DIVIDE LINE 25 BY LINE 4)		26
27	IME PAYMENTS ADJUSTMENT (SEE INSTRUCTIONS)		27
28	IME ADJUSTMENT (SEE INSTRUCTIONS)		28
29	TOTAL IME PAYMENT (SUM OF LINES 22 AND 28)	28,935	29
	DISPROPORTIONATE SHARE ADJUSTMENT		
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-2, PART I, LINE 24 (SEE INSTRUCTIONS)		31
32	SUM OF LINES 30 AND 31		32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		33
34	DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		34
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		40
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		41
42	DIVIDE LINE 41 BY LINE 40 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (SEE INSTRUCTIONS)		43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (LINE 43 DIVIDED BY LINE 41 DIVIDED BY 7 DAYS)		44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRUCTIONS)		45
46	TOTAL ADDITIONAL PAYMENT (LINE 45 TIMES LINE 44 TIMES LINE 41)		46
47	SUBTOTAL (SEE INSTRUCTIONS)	7,406,769	47
48	HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY (SEE INSTRUCTIONS)		48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	7,406,769	49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (FROM WKST L, PARTS I, II, AS APPLICABLE)	580,168	50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (WKST L, PART III) (SEE INSTRUCTIONS)		51

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK [XX] HOSPITAL (15-0167)
APPLICABLE BOX: [] SUB (OTHER)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (FROM WKST E-4, LINE 49) (SEE INSTRUCTIONS)	7,289	52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT		53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		54
55	NET ORGAN ACQUISITION COST (WKST D-4, PART III, COL. 1, LINE 69)		55
56	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)		56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS		57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (WKST D, PART IV, COL. 11, LINE 200)		58
59	TOTAL (SUM OF AMOUNTS ON LINES 49 THROUGH 58)	7,994,226	59
60	PRIMARY PAYER PAYMENTS		60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (LINE 59 MINUS LINE 60)	7,994,226	61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	637,666	62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES		63
64	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	47,826	64
65	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,478	65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	43,572	66
67	SUBTOTAL (LINE 61 PLUS LINE 65 MINUS LINES 62 AND 63)	7,390,038	67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (SEE INSTRUCTIONS)		68
69	OUTLIER PAYMENTS RECONCILIATION		69
70	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		70
71	AMOUNT DUE PROVIDER (LINE 67 MINUS LINE 68 PLUS/MINUS LINES 69 AND 70)	7,390,038	71
72	INTERIM PAYMENTS	7,351,821	72
73	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		73
74	BALANCE DUE PROVIDER/PROGRAM (LINE 71 MINUS THE SUM OF LINES 72 AND 73)	38,217	74
75	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		75
TO BE COMPLETED BY CONTRACTOR			
90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2		90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2		91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (SEE INSTRUCTIONS)		93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (SEE INSTRUCTIONS)		94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (SEE INSTRUCTIONS)		95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (SEE INSTRUCTIONS)		96

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (15-0167) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		7,287,212		519,611	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.		56,180		6,791	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 09/16/2011	8,429		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		NONE	3.50
	.51				3.51
	PROVIDER .52				3.52
	TO .53				3.53
	PROGRAM .54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
	.99	8,429			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)					
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		7,351,821		526,402	4

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50				5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01				6.01
	TO .02				6.02
	PROVIDER .03				6.03
	PROVIDER .04				6.04
	TO .05				6.05
	PROGRAM .06				6.06
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					7

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

PROVIDER CCN: 15-0167 ORTHOPAEDIC HOSPT.AT PARKVIEW
PERIOD FROM 01/01/2011 TO 12/31/2011

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

VERSION: 2011.10
05/30/2012 08:55

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (15-0167) [] CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,630	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,531	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	915	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,192	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	143,088,586	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	173,601	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (15-0167) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES	1
2	MEDICAL AND OTHER SERVICES	355,543 2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)	3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	355,543 4
5	INPATIENT PRIMARY PAYER PAYMENTS	5
6	OUTPATIENT PRIMARY PAYER PAYMENTS	6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	355,543 7
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES	8
9	ANCILLARY SERVICE CHARGES	3,701,275 9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION	11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)	3,701,275 12
CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)	1.000000 15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	3,701,275 16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))	3,345,732 17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))	18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)	19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)	20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	355,543 21
PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS	22
23	OUTLIER PAYMENTS	23
24	PROGRAM CAPITAL PAYMENTS	24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)	25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)	27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)	28
29	SUM OF LINES 27 AND 21	355,543 29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (FROM LINE 18)	30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	355,543 31
32	DEDUCTIBLES	32
33	COINSURANCE	33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)	34
35	UTILIZATION REVIEW	35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	355,543 36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	37
38	SUBTOTAL (LINE 36 ± LINE 37)	355,543 38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)	39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	355,543 40
41	INTERIM PAYMENTS	355,543 41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	43

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)		0.51	12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)		0.17	14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT		0.17	17
18	PER RESIDENT AMOUNT		82,628.66	18
19	APPROVED AMOUNT FOR RESIDENT COSTS		14,047	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			14,047 25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
26	INPATIENT DAYS	PART A	CARE	
27	TOTAL INPATIENT DAYS	1,531	915	26
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	4,192	4,192	27
29	PROGRAM DIRECT GME AMOUNT	0.365219	0.218273	28
30	REDUCTION FOR NURSING/ALLIED HEALTH	5,130	3,066	29
31	NET PROGRAM DIRECT GME AMOUNT		433	30
				7,763 31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			12,022,313 37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			12,022,313 41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			781,930 42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			781,930 44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			12,804,243 45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			0.938932 46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			0.061068 47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			7,763 48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			7,289 49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			474 50

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	72	33	26
27	TOTAL INPATIENT DAYS	4,192	4,192	27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.017176	0.007872	28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR NURSING/ALLIED HEALTH			30
31	NET PROGRAM DIRECT GME AMOUNT			31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 ÷ LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	PART A REASONABLE COST			
37	REASONABLE COST (SEE INSTRUCTIONS)			37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
	PART B REASONABLE COST			
42	REASONABLE COST (SEE INSTRUCTIONS)			42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 ÷ LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 ÷ LINE 45)			47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	3,147,662			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	8,681,738			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	269,799			7
8	PREPAID EXPENSES				8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	12,099,199			11
FIXED ASSETS					
12	LAND				12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	10,495,194			15
16	ACCUMULATED DEPRECIATION	-573,006			16
17	LEASEHOLD IMPROVEMENTS	1,268,249			17
18	ACCUMULATED AMORTIZATION	-209,956			18
19	FIXED EQUIPMENT	133,505			19
20	ACCUMULATED DEPRECIATION	-15,707			20
21	AUTOMOBILES AND TRUCKS	19,893			21
22	ACCUMULATED DEPRECIATION	-4,973			22
23	MAJOR MOVABLE EQUIPMENT	14,094,526			23
24	ACCUMULATED DEPRECIATION	-3,865,018			24
25	MINOR EQUIPMENT DEPRECIABLE	2			25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	21,342,709			30
OTHER ASSETS					
31	INVESTMENTS	232			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	23,813,664			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	23,813,896			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	57,255,804			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	2,505,519			37
38	SALARIES, WAGES & FEES PAYABLE				38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	651,730			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,157,249			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	562,483			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES	18,633,143			49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	19,195,626			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,352,875			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	34,902,929			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	34,902,929			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	57,255,804			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		36,511,556							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		22,656,373							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		59,167,929							3
4 ADDITIONS (CREDIT ADJUSTMENTS)		87,564,278							4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		87,564,278							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		146,732,207							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13		111,829,278							13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)		111,829,278							18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		34,902,929							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	5,837,340		5,837,340	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	5,837,340		5,837,340	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	5,837,340		5,837,340	18
19 ANCILLARY SERVICES	111,546,175	31,359,704	142,905,879	19
20 OUTPATIENT SERVICES				20
21 RHC				21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	117,383,515	31,359,704	148,743,219	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		41,020,698	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		41,020,698	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	148,743,219	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	86,885,480	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	61,857,739	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	41,020,698	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	20,837,041	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	1,823,830	22
23	GOVERNMENTAL APPROPRIATIONS		23
24			24
24.02	OTHER (OTHER OPERATING INCOME)	3,045	24.02
24.06	OTHER (ROUDDING)	1	24.06
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,826,876	25
26	TOTAL (LINE 5 PLUS LINE 25)	22,663,917	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)	7,518	27
27.01	OTHER EXPENSES (LOSS ON INVESTMENT)	26	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	7,544	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	22,656,373	29

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-016) [XX] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
 BOXES [] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	CAPITAL DRG OTHER THAN OUTLIER	554,716	1
2	CAPITAL DRG OUTLIER PAYMENTS	23,178	2
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	11.80	3
4	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	0.17	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	0.0041	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	2,274	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	580,168	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)		17

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((15-016) [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT	
1 CAPITAL DRG OTHER THAN OUTLIER	1
2 CAPITAL DRG OUTLIER PAYMENTS	2
3 TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	3
4 NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	4
5 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	5
6 INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	6
7 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	7
8 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	8
9 SUM OF LINES 7 AND 8	9
10 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	10
11 DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	11
12 TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1 PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2 PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3 NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4 APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5 CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6 PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7 ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8 CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9 CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10 CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12 NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13 CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14 CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15 CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16 CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17 CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PACKED RED BLOOD					62
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
65.01 WOUND CARE					65.01
66 PHYSICAL THERAPY					66
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
115 AMBULATORY SURGICAL CENTER (D.					115
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204