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Board of Directors
Community Memorial Hospital

We have compiled the Hospital and Hospital Health Care Complex Cost Report, Form CMS 2552-96 of Community Memorial Hospital for the year ended June 30, 2008, included in the accompanying prescribed form in accordance with Statements on Standard for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form prescribed by the Centers for Medicare & Medicaid Services information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly; do not express an opinion or any other form of assurance on it.

The Hospital and Hospital Health Care Complex Cost Report, Form CMS 2552-96 is presented in accordance with the requirements of the Centers for Medicare & Medicaid Services, which differ from generally accepted accounting principles. Accordingly, the cost report is not designed for those who are not informed about such differences.

Kerber, Eck & Braeckel LLP

St. Louis, Missouri
November 18, 2008

ROVIDER NO. 14-1306 COMMUNITY MEMORIAL HOSPITAL
ERIOD FROM 07/01/2007 TO 06/30/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05
11/13/2008 17:35

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

WORKSHEET S
PARTS I & II

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

PART I - CERTIFICATION

CHECK APPLICABLE BOX	XX ELECTRONICALLY FILED COST REPORT	DATE: 11/13/2008
	__ MANUALLY SUBMITTED COST REPORT	TIME: 17:35

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 COMMUNITY MEMORIAL HOSPITAL (14-1306) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2007 AND ENDING 06/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/13/2008 17:35
FVQhkVus6jp3egAYbIS6AwgVX2MyV0
SBn6B0I:z80RwIEXHnefUIIzwzqxZa
LRLF0lmTy20jokb:

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38K58FPn050mwIyL

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

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		-94418	-154086		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		61906			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY			1		7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	HEALTH CLINIC					9
100	TOTAL		-32512	-154085		100

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 400 CALDWELL STREET P.O.BOX: 1
1.01 CITY: STAUNTON STATE: IL ZIP CODE: 62088-1499 COUNTY: MACOUPIN 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6	
2	HOSPITAL	COMMUNITY MEMORIAL HOSPITAL	14-1306	08/01/2000	N	O	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	COMMUNITY MEMORIAL HOSPITAL - S/B	14-Z306	08/01/2000	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA	COMMUNITY MEMORIAL HOSPITAL - HHA	14-7166	09/16/1978	N	P	N	9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC							14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2007 TO: 06/30/2008	17
		1 2	
18	TYPE OF CONTROL	2	18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1	19
20	SUBPROVIDER I		20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.				21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?				21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.				21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	N	Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO			21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.				23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.				23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.				24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.				24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO		25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO		25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	12/15/1993		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY. A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				28.02
28.03	STAFFING	0.00		N	28.03
28.04	RECRUITMENT	0.00		N	28.04
28.05	RETENTION OF EMPLOYEES	0.00		N	28.05
28.06	TRAINING	0.00		N	28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO			30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31

MISCELLANEOUS COST REPORTING INFORMATION

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

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

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

TITLE XIX INPATIENT HOSPITAL SERVICES

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

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

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

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?			NO				52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.			NO				52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.							53
53.01	MDH PERIOD:		BEGINNING:		ENDING:			53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:							54
	PREMIUMS: 146538 PAID LOSSES:		AND/OR SELF INSURANCE:					
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.			NO				54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.			NO				55

		DATE	Y/N	LIMIT	Y/N	FEES	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59

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

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		60.01

MULTICAMPUS

61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO	61

	COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 5

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	21	7686	36786.00		753		45		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					543				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	21	7686	36786.00		1296		45		5
6	INTENSIVE CARE UNIT	4	1464	13211.00		553		13		6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	25	9150	49997.00		1849		58		12
13	RPCH VISITS					13988		3435		13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY					10461		314		18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I									24
25	TOTAL	25								25
26	OBSERVATION BED DAYS							16	1	26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	I/P DAYS OBS. BEDS NOT ADMITTED 5.02	I/P DAYS TOTAL ALL PATIENTS 6	O/P VISITS OBS. BEDS ADMITTED 6.01	TRIPS OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES TOTAL 7	LESS I&R REPL PHYS 8	LESS I&R REPL NON-ANES 8	NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		949									1
2	HMO XIX											2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		543									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		7									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		1499									5
6	INTENSIVE CARE UNIT		618									6
7	CORONARY CARE UNIT											7
8	BURN INTENSIVE CARE UNIT											8
9	SURGICAL INTENSIVE CARE UNIT											9
10	OTHER SPECIAL CARE (SPECIFY)											10
11	NURSERY											11
12	TOTAL HOSPITAL		2117							99.00		12
13	RPCH VISITS		28409									13
14	SUBPROVIDER I											14
15	SKILLED NURSING FACILITY											15
16	NURSING FACILITY											16
17	OTHER LONG TERM CARE											17
18	HOME HEALTH AGENCY		11212							18.00		18
20	ASC (DISTINCT PART)											20
21	HOSPICE (DISTINCT PART)											21
23	O/P REHAB PROVIDER											23
24	RHC I											24
25	TOTAL									117.00		25
26	OBSERVATION BED DAYS	15	260	15	245							26
27	AMBULANCE TRIPS											27
28	EMPLOYEE DISCOUNT DAYS											28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	DISCHARGES TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		344	24	436	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		344	24	436	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART II

	PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2) 3	PAID HOURS RELATED TO SALARY IN COL.3 4	AVERAGE HOURLY WAGE (COL.3 / COL.4) 5	DATA SOURCE 6	
	SALARIES							
1	TOTAL SALARIES	4941931			243560.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	943630	-26822		37302.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	230562			3827.00			9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'	255769			4171.00			9.03
10	CONTRACT LABOR: PHYSICIAN PART A	607472			7356.00			10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	991219					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	225771					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	429286	26822		32570.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	143358			6422.00			24
25	LAUNDRY & LINEN SERVICE	19368			2169.00			25
26	HOUSEKEEPING	148031			13529.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	142893	-87268		4995.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		87268		7837.00			28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	154494			5225.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	127344			8646.00			33
34	SOCIAL SERVICE	51567			2013.00			34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART III

	PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED 1	RECLASS. OF SALARIES FROM WKST. A-6 2	ADJUSTED SALARIES (COL.1 + COL.2) 3	PAID HOURS RELATED TO SALARY IN COL.3 4	AVERAGE HOURLY WAGE (COL.3 / COL.4) 5	
1	NET SALARIES	4941931		4941931	243560.00	20.29	1
2	EXCLUDED AREA SALARIES	943630	-26822	916808	37302.00	24.58	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3998301	26822	4025123	206258.00	19.51	3
4	SUBTOTAL OTHER WAGES & REL COSTS	1093803		1093803	15354.00	71.24	4
5	SUBTOTAL WAGE-RELATED COSTS	991219		991219		24.63%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6083323	26822	6110145	221612.00	27.57	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	1216341	26822	1243163	83406.00	14.90	13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA HHA NO.: 14-7166 WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		7221		30	7251	1
2	UNDUPLICATED CENSUS COUNT		346.00		73.00	419.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00

		STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.00		1.00	3
4	DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	2.03		2.03	5
6	DIRECT NURSING SERVICE	7.42		7.42	6
7	NURSING SUPERVISOR	2.15		2.15	7
8	PHYSICAL THERAPY SERVICE	1.07	.32	1.39	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE		.02	.02	10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE		.06	.06	12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE	1.02		1.02	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE	3.48		3.48	16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

		1	1.01	
19	HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD		2	19
20	LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE)		99914	20
20.01			41180	20.01

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7166

WORKSHEET S-4
(CONTINUED)

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 2000

		FULL EPISODES WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL 7	
21	SKILLED NURSING VISITS	4939	149	337	56		86	5567	21
22	SKILLED NURSING VISIT CHARGES	688124	20636	47084	7840		11792	775476	22
23	PHYSICAL THERAPY VISITS	1237	45	6	12		25	1325	23
24	PHYSICAL THERAPY VISIT CHARGES	184569	6705	900	1800		3651	197625	24
25	OCCUPATIONAL THERAPY VISITS	7	4					11	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	1034	600					1634	26
27	SPEECH PATHOLOGY VISITS	27	17					44	27
28	SPEECH PATHOLOGY VISIT CHARGES	4266	2686					6952	28
29	MEDICAL SOCIAL SERVICE VISITS	518	40	19	7		9	593	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	95269	7345	3493	1295		1621	109023	30
31	HOME HEALTH AIDE VISITS	2736	87	6	40		52	2921	31
32	HOME HEALTH AIDE VISIT CHARGES	180383	5741	396	2640		3421	192581	32
33	TOTAL VISITS	9464	342	368	115		172	10461	33
34	OTHER CHARGES								34
35	TOTAL CHARGES	1153645	43713	51873	13575		20485	1283291	35
36	TOTAL NUMBER OF EPISODES	595		130	12		7	744	36
37	TOTAL NUMBER OF OUTLIER EPISODES		7					7	37
38	TOTAL MEDICAL SUPPLY CHARGES	40224	1792	858	827		1532	45233	38

NHCMQ DEMONSTRATION STATISTICAL DATA
STATISTICAL DATA

WORKSHEET S-7

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT		477190	477190	-465514	11676		11676	3
3.01	0301	NEW CAPITAL - BUILDING 1				17078	17078		17078	3.01
3.02	0302	NEW CAPITAL - BUILDING 2				82998	82998		82998	3.02
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				407634	407634	-3456	404178	4
5	0500	EMPLOYEE BENEFITS				1216990	1216990		1216990	5
6	0600	ADMINISTRATIVE & GENERAL	429286	2545213	2974499	-1190828	1783671	-253850	1529821	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	143358	370611	513969	-22153	491816	-632	491184	8
9	0900	LAUNDRY & LINEN SERVICE	19368	11197	30565		30565		30565	9
10	1000	HOUSEKEEPING	148031	18858	166889		166889		166889	10
11	1100	DIETARY	142893	73517	216410	-132166	84244	-420	83824	11
12	1200	CAFETERIA				132166	132166	-31941	100225	12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	154494	6156	160650		160650	-813	159837	14
15	1500	CENTRAL SERVICES & SUPPLY								15
16	1600	PHARMACY								16
17	1700	MEDICAL RECORDS & LIBRARY	127344	23760	151104		151104	-6484	144620	17
18	1800	SOCIAL SERVICE	51567		51567		51567		51567	18
19	1950	OTHER GENERAL SERVICE COST CENT		41532	41532	-41532				19
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	619321	44846	664167		664167		664167	25
26	2600	INTENSIVE CARE UNIT	276982	50	277032		277032		277032	26
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	210149	28161	238310		238310		238310	37
38	3800	RECOVERY ROOM	37028		37028		37028		37028	38
40	4000	ANESTHESIOLOGY		212699	212699		212699	-210502	2197	40
41	4100	RADIOLOGY-DIAGNOSTIC	356011	522215	878226		878226	-2005	876221	41
44	4400	LABORATORY	454403	609359	1063762		1063762	-58650	1005112	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
48	4800	INTRAVENOUS THERAPY		6369	6369		6369		6369	48
49	4900	RESPIRATORY THERAPY	138321	144323	282644	-25135	257509	-19090	238419	49
50	5000	PHYSICAL THERAPY	99862	152802	252664		252664		252664	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY		3419	3419		3419		3419	52
55	5500	MEDICAL SUPPLIES CHARGED TO PAT	73534	195766	269300	25135	294435	-1721	292714	55
56	5600	DRUGS CHARGED TO PATIENTS	145460	1208807	1354267		1354267	-979	1353288	56
59	3140	CARDIOLOGY	52869	1317	54186		54186	-6231	47955	59
		OUTPATIENT SERVICE COST CENTERS								
60	6000	CLINIC	40749	2980	43729		43729	-16505	27224	60
61	6100	EMERGENCY	277271	791755	1069026		1069026	-117911	951115	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC								63.50
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY	770676	156463	927139	-27058	900081	-11717	888364	71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
90	9000	OTHER CAPITAL RELATED COSTS		20790	20790	-20790				90
95		SUBTOTALS	4768977	7670155	12439132	-43175	12395957	-742907	11653050	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800	PHYSICIANS' PRIVATE OFFICES	172954	40621	213575	27909	241484		241484	98
100	7951	RENTAL PROPERTY				8339	8339		8339	100
100.01	7953	MEDICAL OFFICE BUILDINGS		104450	104450	6927	111377		111377	100.01
101		TOTAL	4941931	7815226	12757157		12757157	-742907	12014250	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION EXPENSE	A	NEW CAPITAL - BUILDING 1	3.01		15035	1
2	DEPRECIATION EXPENSE	A	NEW CAPITAL - BUILDING 2	3.02		75397	2
3	DEPRECIATION EXPENSE	A	HOME HEALTH AGENCY	71		4395	3
4	DEPRECIATION EXPENSE	A	MEDICAL OFFICE BUILDINGS	100.01		3990	4
5	DEPRECIATION EXPENSE	A	OPERATION OF PLANT	8		828	5
6	DEPRECIATION EXPENSE	A	RENTAL PROPERTY	100		7679	6
7	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		358686	7
8	EMPLOYEE BENEFITS	B	EMPLOYEE BENEFITS	5		1216990	8
9	INTEREST EXPENSE	C					9
10	EQUIPMENT RENTAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4		41532	10
11	INSURANCE EXPENSE	E					11
12	INSURANCE EXPENSE	E					12
13	INSURANCE EXPENSE	E	RENTAL PROPERTY	100		660	13
14	CAFETERIA EXPENSE	F	CAFETERIA	12	87268	44898	14
15	HOME HEALTH UTILITIES	G	OPERATION OF PLANT	8		4901	15
16	OXYGEN EXPENSE	H	MEDICAL SUPPLIES CHARGED TO P	55		25135	16
17	HHA BILLER SALARY	I	ADMINISTRATIVE & GENERAL	6	26822		17
18	PLANT OPERATION MAINTENANCE	J	PHYSICIANS' PRIVATE OFFICES	98		27909	18
19	MAINTENANCE - BMB	K					19
20	UTILITIES - SMB & RENTAL PROPERTY	L					20
21	UTILITIES - SMB & RENTAL PROPERTY	L					21
22	CAPITAL INSURANCE	M	NEW CAP REL COSTS-BLDG & FIXT	3		496	22
23	CAPITAL INSURANCE	M	NEW CAPITAL - BUILDING 1	3.01		2043	23
24	CAPITAL INSURANCE	M	NEW CAPITAL - BUILDING 2	3.02		7601	24
25	CAPITAL INSURANCE	M	HOME HEALTH AGENCY	71		270	25
26	CAPITAL INSURANCE	M	MEDICAL OFFICE BUILDINGS	100.01		2937	26
27	CAPITAL INSURANCE	M	OPERATION OF PLANT	8		27	27
28	CAPITAL INSURANCE	M	NEW CAP REL COSTS-MVBLE EQUIP	4		7416	28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				114090	1848825	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
	1		6	7	8	9	10	
1	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		15035	9	1
2	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		75397	9	2
3	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		4395	9	3
4	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		3990	9	4
5	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		828	9	5
6	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		7679	9	6
7	DEPRECIATION EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		358686	9	7
8	EMPLOYEE BENEFITS	B	ADMINISTRATIVE & GENERAL	6		1216990		8
9	INTEREST EXPENSE	C					11	9
10	EQUIPMENT RENTAL	D	OTHER GENERAL SERVICE COST CE	19		41532	10	10
11	INSURANCE EXPENSE	E						11
12	INSURANCE EXPENSE	E						12
13	INSURANCE EXPENSE	E	ADMINISTRATIVE & GENERAL	6		660		13
14	CAFETERIA EXPENSE	F	DIETARY	11	87268	44898		14
15	HOME HEALTH UTILITIES	G	HOME HEALTH AGENCY	71		4901		15
16	OXYGEN EXPENSE	H	RESPIRATORY THERAPY	49		25135		16
17	HHA BILLER SALARY	I	HOME HEALTH AGENCY	71	26822			17
18	PLANT OPERATION MAINTENANCE	J	OPERATION OF PLANT	8		27909		18
19	MAINTENANCE - BMB	K						19
20	UTILITIES - SMB & RENTAL PROPERTY	L						20
21	UTILITIES - SMB & RENTAL PROPERTY	L						21
22	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		496	12	22
23	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		2043	12	23
24	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		7601	12	24
25	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		270	12	25
26	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		2937	12	26
27	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		27	12	27
28	CAPITAL INSURANCE	M	OTHER CAPITAL RELATED COSTS	90		7416	12	28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				114090	1848825		36

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

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	185004	150500		150500		335504		1
2	LAND IMPROVEMENTS	312399					312399	133360	2
3	BUILDINGS AND FIXTURES	6001656	167009		167009	35295	6133370	2794419	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	160662				13983	146679	119177	5
6	MOVABLE EQUIPMENT	2977543	267909		267909	74830	3170622	1350885	6
7	SUBTOTAL	9637264	585418		585418	124108	10098574	4397841	7
8	RECONCILING ITEMS								8
9	TOTAL	9637264	585418		585418	124108	10098574	4397841	9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS (1)	CAPITALIZED LEASES (2)	GROSS ASSETS FOR RATIO (3)	RATIO (4)	ALLOCATION OF OTHER CAPITAL: INSURANCE (5)	TAXES (6)	OTHER CAPITAL-RELATED COSTS (7)	TOTAL (8)	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT	312399		312399	.032486					3
3.01	NEW CAPITAL - BUILDING 1	6133370		6133370	.637804					3.01
3.02	NEW CAPITAL - BUILDING 2				.000000					3.02
4	NEW CAP REL COSTS-MVBLE EQUIP	3170622		3170622	.329710					4
5	TOTAL	9616391		9616391	1.000000					5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (12)	TAXES (13)	OTHER CAPITAL-RELATED COSTS (14)	TOTAL (15)	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	11180			496			11676	3
3.01	NEW CAPITAL - BUILDING 1	15035			2043			17078	3.01
3.02	NEW CAPITAL - BUILDING 2	75397			7601			82998	3.02
4	NEW CAP REL COSTS-MVBLE EQUIP	358686	41532		7416		-3456	404178	4
5	TOTAL	460298	41532		17556		-3456	515930	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION (9)	LEASE (10)	INTEREST (11)	INSURANCE (12)	TAXES (13)	OTHER CAPITAL-RELATED COSTS (14)	TOTAL (15)	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	477190						477190	3
3.01	NEW CAPITAL - BUILDING 1								3.01
3.02	NEW CAPITAL - BUILDING 2								3.02
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	TOTAL	477190						477190	5

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 COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B		NEW CAP REL COSTS-MVBLE EQUIP	4	11	4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES	B	-58333	ADMINISTRATIVE & GENERAL	6		7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-14770	CLINIC	60		8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-5245	ADMINISTRATIVE & GENERAL	6		9
10	TELEVISION AND RADIO SERVICE	A	-632	OPERATION OF PLANT	8		10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-197386				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1					14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-31941	CAFETERIA	12		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1721	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-979	DRUGS CHARGED TO PATIENTS	56		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3740	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)						21
22	VENDING MACHINES						22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51		35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52		36
37	AHA FEES RELATED TO LOBBYING	A	-416	ADMINISTRATIVE & GENERAL	6		37
38	IHA FEES RELATED TO LOBBYING	A	-5752	ADMINISTRATIVE & GENERAL	6		38
39	TRANSCRIPTION SERVICE	B	-2744	MEDICAL RECORDS & LIBRARY	17		39
40	TELEVISION SATELLITE	A	-3456	NEW CAP REL COSTS-MVBLE EQUIP	4	14	40
41	MISC. OPERATING REVENUE	B	-60	ADMINISTRATIVE & GENERAL	6		41
42	X-RAY FILM COPYING	B	-2005	RADIOLOGY-DIAGNOSTIC	41		42
43	INSERVICE EDUCATION	B	-813	NURSING ADMINISTRATION	14		43
44	CARDIAC REHAB	B	-6231	CARDIOLOGY	59		44
45	DIABETIC CONSULTATION	B	-420	DIETARY	11		45
46	PUBLIC RELATIONS	A	-49029	ADMINISTRATIVE & GENERAL	6		46
47	PUBLIC RELATIONS	B	-418	ADMINISTRATIVE & GENERAL	6		47
48	HOME HEALTH CONSULTATION	B	-11717	HOME HEALTH AGENCY	71		48
49	TAXES	A	-2053	ADMINISTRATIVE & GENERAL	6		49
49.01	NON-PHYSICIAN ANESTHETIST	A	-210502	ANESTHESIOLOGY	40		49.01
49.02	PROVIDER TAX ASSESSMENT	A	-132544	ADMINISTRATIVE & GENERAL	6		49.02
50	TOTAL		-742907				50

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

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

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

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

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

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

		-------- 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		
1							1
2							2
3							3
4							4
5							5

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	AGGREGATE	58650	58650					
2	49	RESPIRATORY THERAPY	AGGREGATE	19090	19090					
3	60	CLINIC	AGGREGATE	1735	1735					
4	61	EMERGENCY	AGGREGATE	725383	117911	607472				
101		TOTAL		804858	197386	607472				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	44	LABORATORY	AGGREGATE							58650
2	49	RESPIRATORY THERAPY	AGGREGATE							19090
3	60	CLINIC	AGGREGATE							1735
4	61	EMERGENCY	AGGREGATE							117911
101		TOTAL								197386

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)		1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK		2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS	17	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS	3	6
7	STANDARD TRAVEL EXPENSE RATE	3.75	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		22.25	10.50			9
10	AHSEA		57.98	43.49			10
11	STANDARD TRAVEL ALLOWANCE	28.99	28.99	21.75			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	1290	15
16	ASSISTANTS	457	16
17	SUBTOTAL ALLOWANCE AMOUNT	1747	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	1747	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	1747	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS		24
25	ASSISTANTS		25
26	SUBTOTAL		26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE		28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS	493	36
37	ASSISTANTS	65	37
38	SUBTOTAL	558	38
39	STANDARD TRAVEL EXPENSE	75	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	633	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD						47
48	OVERTIME RATE						48
49	TOTAL OVERTIME						49
	CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY						50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50						51
	DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT						52
53	OVERTIME COST LIMITATION						53
54	MAXIMUM OVERTIME COST						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA						55
56	OVERTIME ALLOWANCE						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	1747	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	633	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	2380	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	1520	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[XX] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL		66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	1520	66.31
67	TOTAL COST	1520	67
68	RATIO OF HOSPITAL COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL		68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	1.000000	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	26	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	390	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	95	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	24	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS	528	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS	141	6
7	STANDARD TRAVEL EXPENSE RATE	3.45	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED	8.00	1958.00	1126.50			9
10	AHSEA	61.18	61.18	45.89			10
11	STANDARD TRAVEL ALLOWANCE	30.59	30.59	22.95			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS	489	14
15	THERAPISTS	119790	15
16	ASSISTANTS	51695	16
17	SUBTOTAL ALLOWANCE AMOUNT	171974	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	171974	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	171974	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[ ] OCCUPATIONAL [XX] PHYSICAL [ ] RESPIRATORY [ ] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	2906	24
25	ASSISTANTS	551	25
26	SUBTOTAL	3457	26
27	STANDARD TRAVEL EXPENSE	411	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	3868	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	3868	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

	STANDARD TRAVEL EXPENSE		
36	THERAPISTS	16152	36
37	ASSISTANTS	3236	37
38	SUBTOTAL	19388	38
39	STANDARD TRAVEL EXPENSE	2308	39
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
	TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	21696	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46