

WORKSHEET S
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1310	I	FROM 4/1/2007	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 3/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 8/5/2008 TIME 13:54

PART I - 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 BY 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:

MENDOTA COMMUNITY HOSPITAL 14-1310

FOR THE COST REPORTING PERIOD BEGINNING 4/1/2007 AND ENDING 3/31/2008 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.

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	-13,767	251,306	0	0
3	SWING BED - SNF	0	75,242	0	0	0
7	HOSPITAL-BASED HHA	0	0	-17	0	0
100	TOTAL	0	61,475	251,289	0	0

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 662 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: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 1315 MEMORIAL DRIVE P.O. BOX:
 1.01 CITY: MENDOTA STATE: IL ZIP CODE: 61342-7461 COUNTY: LASALLE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	MENDOTA COMMUNITY HOSPITAL	14-1310	1/15/2001	N	0	0
04.00	SWING BED - SNF	MENDOTA COMMUNITY SWINGBED-SNF	14-Z310	1/25/2001	N	0	N
09.00	HOSPITAL-BASED HHA	MENDOTA COMMUNITY HOSPITAL - HHA	14-7616	9/15/1995	N	0	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 4/ 1/2007 TO: 3/31/2008

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORT 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.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN OR (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN OR (2) RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE. / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2.

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?

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.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9. N

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE 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)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS 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)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.

26.01 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

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. Y 1/25/2001

TITLE XIX INPATIENT SERVICES
 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? Y
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAP 10?
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE N
 40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P. O. BOX:
 40.03 CITY: STATE: ZIP CODE:
 41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-11, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? Y
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? Y
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? Y
 46 IF YOU ARE PARTICIPATING IN THE NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "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
47.00 HOSPITAL	1 N	2 N	3 N	4 N	5 N
50.00 HHA	N	N			

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
 53 IF YOU ARE 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. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 270,825
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
 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. N
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEE\$ 4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FACILITY INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULE AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. N 0.00 0					
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULE AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0					
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0					

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 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% FEDERAL 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. N

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 "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). 0
 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N
 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) N
 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). 0

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	21	7,686	72,384.00			2,312	169
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						1,240	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,686	72,384.00			3,552	169
6 INTENSIVE CARE UNIT	4	1,464	9,360.00			246	43
12 TOTAL	25	9,150	81,744.00			3,798	212
13 RPCH VISITS							
18 HOME HEALTH AGENCY						1,491	
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS TOTAL OBSERVATION ADMITTED 6.01	OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			3,016				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,240				
4 ADULTS & PED-SB NF			71				
5 TOTAL ADULTS AND PEDS			4,327				
6 INTENSIVE CARE UNIT			390				
12 TOTAL			4,717				
13 RPCH VISITS							
18 HOME HEALTH AGENCY			2,288				
25 TOTAL							
26 OBSERVATION BED DAYS			485		485		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS						70	1,007
2 HMO					662		
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
12 TOTAL		230.82			662	70	1,007
13 RPCH VISITS							
18 HOME HEALTH AGENCY		5.44					
25 TOTAL		236.26					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	82	4	28
2 UNDUPLICATED CENSUS COUNT		145.00	8.00	49.00
TOTAL				
5				
1 HOME HEALTH AIDE HOURS	114			
2 UNDUPLICATED CENSUS COUNT	202.00			
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)				
ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK				
	40.00			
HHA NO. OF FTE EMPLOYEES (2080 HRS)				
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.07		1.07	
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				
5 OTHER ADMINISTRATIVE PERSONEL	.70		.70	
6 DIRECTING NURSING SERVICE	3.58		3.58	
7 NURSING SUPERVISOR				
8 PHYSICAL THERAPY SERVICE				
9 PHYSICAL THERAPY SUPERVISOR				
10 OCCUPATIONAL THERAPY SERVICE				
11 OCCUPATIONAL THERAPY SUPERVISOR				
12 SPEECH PATHOLOGY SERVICE				
13 SPEECH PATHOLOGY SUPERVISOR				
14 MEDICAL SOCIAL SERVICE				
15 MEDICAL SOCIAL SERVICE SUPERVISOR				
16 HOME HEALTH AIDE				
17 HOME HEALTH AIDE SUPERVISOR	.09		.09	
18				
HOME HEALTH AGENCY MSA CODES				
	1	1.01		
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	1	0		
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).	9914			

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

	WITHOUT OUTLIERS 1	FULL EPIISODES WITH OUTLIERS 2	LUPA EPIISODES 3	PEP ONLY EPIISODES 4
21 SKILLED NURSING VISITS	1,198	0	56	19
22 SKILLED NURSING VISIT CHARGES	230,763	0	10,808	3,667
23 PHYSICAL THERAPY VISITS	117	0	4	10
24 PHYSICAL THERAPY VISIT CHARGES	22,515	0	772	1,930
25 OCCUPATIONAL THERAPY VISITS	22	0	0	1
26 OCCUPATIONAL THERAPY VISIT CHARGES	4,246	0	0	193
27 SPEECH PATHOLOGY VISITS	1	0	0	1
28 SPEECH PATHOLOGY VISIT CHARGES	193	0	0	193
29 MEDICAL SOCIAL SERVICE VISITS	10	0	1	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	2,714	0	273	0
31 HOME HEALTH AIDE VISITS	41	0	0	0
32 HOME HEALTH AIDE VISIT CHARGES	4,633	0	0	0
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29 & 31)	1,389	0	61	31
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22, 24, 26, 28, 30, 32 & 34)	265,064	0	11,853	5,983
36 TOTAL NUMBER OF EPIISODES (STANDARD/NON OUTLIER)	1,126	0	46	31
37 TOTAL NUMBER OF OUTLIER EPIISODES	0	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	12,882	0	566	0

	SCIC WITHIN A PEP 5	SCIC ONLY EPIISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	8	1,281
22 SKILLED NURSING VISIT CHARGES	0	1,544	246,782
23 PHYSICAL THERAPY VISITS	0	1	132
24 PHYSICAL THERAPY VISIT CHARGES	0	193	25,410
25 OCCUPATIONAL THERAPY VISITS	0	1	24
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	193	4,632
27 SPEECH PATHOLOGY VISITS	0	0	2
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	386
29 MEDICAL SOCIAL SERVICE VISITS	0	0	11
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	2,987
31 HOME HEALTH AIDE VISITS	0	0	41
32 HOME HEALTH AIDE VISIT CHARGES	0	0	4,633
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29 & 31)	0	10	1,491
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22, 24, 26, 28, 30, 32 & 34)	0	1,930	284,830
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	10	1,213
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	34	13,482

HOSPITAL UNCOMPENSATED CARE DATA

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	601,146
17.01	GROSS MEDICAID REVENUES	4,093,636
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	4,694,782
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.475547
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST. (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	4,093,636
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	1,946,716
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	601,146
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	285,873
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	1,946,716

COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE
		1	2	3	4	5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS- BLDG & FIXT		324,001	324,001	-42,257	281,744
4	0400 NEW CAP REL COSTS- MVBLE EQUIP		840,986	840,986	82,243	923,229
5	0500 EMPLOYEE BENEFITS		2,692,259	2,692,259	333,772	3,026,031
6.01	0610 BUSINESS OFFICE	222,273	134,109	356,382	135,801	492,183
6.02	0611 DATA PROCESSING	286,199	271,743	557,942		557,942
6.03	0612 ADMITTING	140,014	4,068	144,082		144,082
6.04	0660 OTHER ADMINISTRATIVE AND GENERAL	873,942	1,620,851	2,494,793	-405,398	2,089,395
8	0800 OPERATION OF PLANT	339,930	563,219	903,149	-9,518	893,631
9	0900 LAUNDRY & LINEN SERVICE		78,384	78,384		78,384
10	1000 HOUSEKEEPING	294,774	46,239	341,013		341,013
11	1100 DIETARY	280,595	198,398	478,993	-262,869	216,124
12	1200 CAFETERIA				262,869	262,869
17	1700 MEDICAL RECORDS & LIBRARY	267,954	194,865	462,819		462,819
18	1800 SOCIAL SERVICE	159,300	2,578	161,878		161,878
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,845,797	191,454	2,037,251		2,037,251
26	2600 INTENSIVE CARE UNIT	433,583	84,964	518,547		518,547
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	387,725	330,505	718,230	-113,239	604,991
38	3800 RECOVERY ROOM	13,743	3,008	16,751		16,751
40	4000 ANESTHESIOLOGY	625,918	84,081	709,999	-3,317	706,682
41	4100 RADIOLOGY-DIAGNOSTIC	505,108	1,433,098	1,938,206	-123,129	1,815,077
44	4400 LABORATORY	656,785	809,552	1,466,337		1,466,337
49	4900 RESPIRATORY THERAPY	372,040	62,117	434,157	-19,784	414,373
50	5000 PHYSICAL THERAPY	211,615	28,116	239,731		239,731
51	5100 OCCUPATIONAL THERAPY	17,708	80,514	98,222		98,222
52	5200 SPEECH PATHOLOGY		7,440	7,440		7,440
53	5300 ELECTROCARDIOLOGY	37,128	84,169	121,297		121,297
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	53,251	171,834	225,085	120,286	345,371
56	5600 DRUGS CHARGED TO PATIENTS	244,298	1,231,204	1,475,502	70,745	1,546,247
58	5800 ASC (NON-DISTINCT PART)	83,010	19,614	102,624		102,624
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	227,678	127,077	354,755		354,755
61	6100 EMERGENCY	598,214	1,677,119	2,275,333		2,275,333
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
71	7100 HOME HEALTH AGENCY	300,972	47,563	348,535	-472	348,063
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		19,549	19,549	-19,549	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	9,479,554	13,464,678	22,944,232	6,184	22,950,416
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES	1,528,415	320,724	1,849,139	-6,184	1,842,955
101	TOTAL	11,007,969	13,785,402	24,793,371	-0-	24,793,371

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT		281,744
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		923,229
5	0500 EMPLOYEE BENEFITS	- 48,507	2,977,524
6.01	0610 BUSINESS OFFICE		492,183
6.02	0611 DATA PROCESSING		557,942
6.03	0612 ADMITTING		144,082
6.04	0660 OTHER ADMINISTRATIVE AND GENERAL	- 637,485	1,451,910
8	0800 OPERATION OF PLANT		893,631
9	0900 LAUNDRY & LINEN SERVICE		78,384
10	1000 HOUSEKEEPING		341,013
11	1100 DIETARY	- 20,919	195,205
12	1200 CAFETERIA	- 50,356	212,513
17	1700 MEDICAL RECORDS & LIBRARY	- 15,524	447,295
18	1800 SOCIAL SERVICE		161,878
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		2,037,251
26	2600 INTENSIVE CARE UNIT		518,547
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		604,991
38	3800 RECOVERY ROOM		16,751
40	4000 ANESTHESIOLOGY	- 650,575	56,107
41	4100 RADIOLOGY-DIAGNOSTIC	- 850	1,814,227
44	4400 LABORATORY	- 15,000	1,451,337
49	4900 RESPIRATORY THERAPY		414,373
50	5000 PHYSICAL THERAPY		239,731
51	5100 OCCUPATIONAL THERAPY		98,222
52	5200 SPEECH PATHOLOGY		7,440
53	5300 ELECTROCARDIOLOGY	- 56,321	64,976
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		345,371
56	5600 DRUGS CHARGED TO PATIENTS		1,546,247
58	5800 ASC (NON-DISTINCT PART)		102,624
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	- 103,095	251,660
61	6100 EMERGENCY	- 721,704	1,553,629
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
71	7100 HOME HEALTH AGENCY	- 4,448	343,615
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		- 0-
90	9000 OTHER CAPITAL RELATED COSTS		- 0-
95	SUBTOTALS	- 2,324,784	20,625,632
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		1,842,955
101	TOTAL	- 2,324,784	22,468,587

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	BUSINESS OFFICE	0610	NONPATIENT TELEPHONES
6.02	DATA PROCESSING	0611	NONPATIENT TELEPHONES
6.03	ADMINISTRATIVE	0612	NONPATIENT TELEPHONES
6.04	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
58	ASC (NON-DISTINCT PART)	5800	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:
141310PERIOD:
FROM 4/1/2007
TO 3/31/2008PREPARED 8/15/2008
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1) 1	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 CAFETERIA EXPENSES	A	CAFETERIA	12	153,989	108,880
2 PHYSICIAN CLINIC NON-OPERATING EXPS	B	PHYSICIANS' PRIVATE OFFICES	98		45,452
3 PHYSICIAN CLINIC BLDG DEPRECIATION	C	PHYSICIANS' PRIVATE OFFICES	98		55,129
4 PHYSICIAN CLINIC MME DEPRECIATION	D	PHYSICIANS' PRIVATE OFFICES	98		19,518
5 PROPERTY INSURANCE	E	OTHER CAPITAL RELATED COSTS	90		26,174
6 HUMAN RESOURCES	F	EMPLOYEE BENEFITS	5	49,794	117,338
7 IMPLANTS & OXYGEN	I	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		126,296
8					
9 DRUGS CHARGED TO PATIENTS	J	DRUGS CHARGED TO PATIENTS	56		70,745
10					
11					
12					
13					
14 WORKMAN'S COMP EXPENSE	K	EMPLOYEE BENEFITS	5		166,640
15 INTEREST EXPENSE	L	NEW CAP REL COSTS-MVBLE EQUIP	4		19,549
16 PHYSICIAN CLINIC CBO & MAINT SAL	M	BUSINESS OFFICE	6.01	90,660	45,141
17		PHYSICIANS' PRIVATE OFFICES	98	9,518	
18 RADIOLOGY CONTRACTED EQUIP	N	NEW CAP REL COSTS-MVBLE EQUIP	4		68,910
36 TOTAL RECLASSIFICATIONS				303,961	869,772

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

141310

FROM 4/1/2007

WORKSHEET A-6

TO 3/31/2008

EXPLANATION OF RECLASSIFICATION	CODE		DECREASE		SALARY	OTHER	A-7 REF 10
	(1)	COST CENTER	LINE NO				
	1	6	7		8	9	
1 CAFETERIA EXPENSES	A	DIETARY	11		153,989	108,880	
2 PHYSICIAN CLINIC NON-OPERATING EXPS	B	OTHER ADMINISTRATIVE AND GENERAL	6.04			45,452	
3 PHYSICIAN CLINIC BLDG DEPRECIATION	C	NEW CAP REL COSTS-BLDG & FIXT	3			55,129	9
4 PHYSICIAN CLINIC MME DEPRECIATION	D	NEW CAP REL COSTS-MVBLE EQUIP	4			19,518	9
5 PROPERTY INSURANCE	E	OTHER ADMINISTRATIVE AND GENERAL	6.04			26,174	12
6 HUMAN RESOURCES	F	OTHER ADMINISTRATIVE AND GENERAL	6.04		49,794	117,338	
7 IMPLANTS & OXYGEN	I	OPERATING ROOM	37			113,239	
8		RESPIRATORY THERAPY	49			13,057	
9 DRUGS CHARGED TO PATIENTS	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			6,010	
10		RADIOLOGY-DIAGNOSTIC	41			54,219	
11		ANESTHESIOLOGY	40			3,317	
12		RESPIRATORY THERAPY	49			6,727	
13		HOME HEALTH AGENCY	71			472	
14 WORKMAN'S COMP EXPENSE	K	OTHER ADMINISTRATIVE AND GENERAL	6.04			166,640	
15 INTEREST EXPENSE	L	INTEREST EXPENSE	88			19,549	11
16 PHYSICIAN CLINIC CBO & MAINT SAL	M	PHYSICIANS' PRIVATE OFFICES	98		90,660	45,141	
17		OPERATION OF PLANT	8		9,518		
18 RADIOLOGY CONTRACTED EQUIP	N	RADIOLOGY-DIAGNOSTIC	41			68,910	10
36 TOTAL RECLASSIFICATIONS					303,961	869,772	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

PROVIDER NO: 141310

PERIOD: FROM 4/1/2007 TO 3/31/2008

PREPARED 8/15/2008 WORKSHEET A-6 NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : CAFETERIA EXPENSES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	262,869
TOTAL RECLASSIFICATIONS FOR CODE A		262,869

DECREASE		
COST CENTER	LINE	AMOUNT
DIETARY	11	262,869
TOTAL RECLASSIFICATIONS FOR CODE A		262,869

RECLASS CODE: B
EXPLANATION : PHYSICIAN CLINIC NON-OPERATING EXPS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	45,452
TOTAL RECLASSIFICATIONS FOR CODE B		45,452

DECREASE		
COST CENTER	LINE	AMOUNT
OTHER ADMINISTRATIVE AND GENER	6.04	45,452
TOTAL RECLASSIFICATIONS FOR CODE B		45,452

RECLASS CODE: C
EXPLANATION : PHYSICIAN CLINIC BLDG DEPRECIATION

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	55,129
TOTAL RECLASSIFICATIONS FOR CODE C		55,129

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-BLDG & FIXT	3	55,129
TOTAL RECLASSIFICATIONS FOR CODE C		55,129

RECLASS CODE: D
EXPLANATION : PHYSICIAN CLINIC MME DEPRECIATION

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	19,518
TOTAL RECLASSIFICATIONS FOR CODE D		19,518

DECREASE		
COST CENTER	LINE	AMOUNT
NEW CAP REL COSTS-MVBLE EQUIP	4	19,518
TOTAL RECLASSIFICATIONS FOR CODE D		19,518

RECLASS CODE: E
EXPLANATION : PROPERTY INSURANCE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	26,174
TOTAL RECLASSIFICATIONS FOR CODE E		26,174

DECREASE		
COST CENTER	LINE	AMOUNT
OTHER ADMINISTRATIVE AND GENER	6.04	26,174
TOTAL RECLASSIFICATIONS FOR CODE E		26,174

RECLASS CODE: F
EXPLANATION : HUMAN RESOURCES

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	EMPLOYEE BENEFITS	167,132
TOTAL RECLASSIFICATIONS FOR CODE F		167,132

DECREASE		
COST CENTER	LINE	AMOUNT
OTHER ADMINISTRATIVE AND GENER	6.04	167,132
TOTAL RECLASSIFICATIONS FOR CODE F		167,132

RECLASS CODE: I
EXPLANATION : IMPLANTS & OXYGEN

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	126,296
2.00		0
TOTAL RECLASSIFICATIONS FOR CODE I		126,296

DECREASE		
COST CENTER	LINE	AMOUNT
OPERATING ROOM	37	113,239
RESPIRATORY THERAPY	49	13,057
TOTAL RECLASSIFICATIONS FOR CODE I		126,296

RECLASS CODE: J
EXPLANATION : DRUGS CHARGED TO PATIENTS

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	70,745
2.00		0
3.00		0
4.00		0
5.00		0
TOTAL RECLASSIFICATIONS FOR CODE J		70,745

DECREASE		
COST CENTER	LINE	AMOUNT
MEDICAL SUPPLIES CHARGED TO PA	55	6,010
RADIOLOGY-DIAGNOSTIC	41	54,219
ANESTHESIOLOGY	40	3,317
RESPIRATORY THERAPY	49	6,727
HOME HEALTH AGENCY	71	472
TOTAL RECLASSIFICATIONS FOR CODE J		70,745

RECLASS CODE: K
EXPLANATION : WORKMAN'S COMP EXPENSE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	EMPLOYEE BENEFITS	166,640
TOTAL RECLASSIFICATIONS FOR CODE K		166,640

DECREASE		
COST CENTER	LINE	AMOUNT
OTHER ADMINISTRATIVE AND GENER	6.04	166,640
TOTAL RECLASSIFICATIONS FOR CODE K		166,640

RECLASS CODE: L
EXPLANATION : INTEREST EXPENSE

INCREASE		
LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	19,549
TOTAL RECLASSIFICATIONS FOR CODE L		19,549

DECREASE		
COST CENTER	LINE	AMOUNT
INTEREST EXPENSE	88	19,549
TOTAL RECLASSIFICATIONS FOR CODE L		19,549

RECLASSIFICATIONS

PROVIDER NO:
141310

PERIOD:
FROM 4/1/2007
TO 3/31/2008

PREPARED 8/15/2008
WORKSHEET A-6
NOT A CMS WORKSHEET

RECLASS CODE: M
EXPLANATION : PHYSICIAN CLINIC CBO & MAINT SAL

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	BUSINESS OFFICE	6.01	135,801
2.00	PHYSICIANS' PRIVATE OFFICES	98	9,518
TOTAL RECLASSIFICATIONS FOR CODE M			145,319

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
PHYSICIANS' PRIVATE OFFICES	98	135,801
OPERATION OF PLANT	8	9,518
		145,319

RECLASS CODE: N
EXPLANATION : RADIOLOGY CONTRACTED EQUIP

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	68,910
TOTAL RECLASSIFICATIONS FOR CODE N			68,910

----- DECREASE -----		
COST CENTER	LINE	AMOUNT
RADIOLOGY-DIAGNOSTIC	41	68,910
		68,910

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	7,788						7,788	
2	LAND IMPROVEMENTS	445,118	9,702		9,702	5,912	448,908		
3	BUILDINGS & FIXTURE	8,592,709	400,060		400,060		8,992,769		
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT	2,887,983	152,118		152,118		3,040,101		
6	MOVABLE EQUIPMENT	7,501,892	224,737		224,737	66,097	7,660,532		
7	SUBTOTAL	19,435,490	786,617		786,617	72,009	20,150,098		
8	RECONCILING ITEMS								
9	TOTAL	19,435,490	786,617		786,617	72,009	20,150,098		

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
			CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	9,449,465		9,449,465	.491803	12,872			12,872
4	NEW CAP REL COSTS-MV	10,700,633	936,167	9,764,466	.508197	13,302			13,302
5	TOTAL	20,150,098	936,167	19,213,931	1.000000	26,174			26,174

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	268,872			12,872			281,744
4	NEW CAP REL COSTS-MV	821,468	68,910	19,549	13,302			923,229
5	TOTAL	1,090,340	68,910	19,549	26,174			1,204,973

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	324,001						324,001
4	NEW CAP REL COSTS-MV	840,986						840,986
5	TOTAL	1,164,987						1,164,987

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
 (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
 Columns 9 through 14 should include related Worksheet A-6 recl assifications and Worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
	1	2	3	4	5
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-2,526	OTHER ADMINISTRATIVE AND	6.04	
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-20,000	OTHER ADMINISTRATIVE AND	6.04	
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,529,340			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-48,708	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-15,524	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN, FEES, BOOKS, ETC.)					
22 VENDING MACHINES	B	-1,648	CAFETERIA	12	
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 MEALS ON WHEELS	B	-16,569	DIETARY	11	
38 DIETARY REVENUE	B	-4,350	DIETARY	11	
39 MISCELLANEOUS	B	-125,537	OTHER ADMINISTRATIVE AND	6.04	
40 AMBULANCE SUPPLY REVENUE	B	-8,710	EMERGENCY	61	
41 HEALTH FAIR REVENUE	B	-450	OTHER ADMINISTRATIVE AND	6.04	
42 COMMUNITY HEALTH EXPENSE	A	-8,969	OTHER ADMINISTRATIVE AND	6.04	
43 LOBBYING EXPENSE	A	-12,003	OTHER ADMINISTRATIVE AND	6.04	
44 HOME HEALTH MARKETING EXPENSE	A	-4,448	HOME HEALTH AGENCY	71	
45 HOSPITAL MARKETING EXPENSE	A	-130,244	OTHER ADMINISTRATIVE AND	6.04	
46 MARKETING BENEFIT EXPENSE	A	-6,980	EMPLOYEE BENEFITS	5	
47 CRNA BENEFIT EXPENSE	A	-41,527	EMPLOYEE BENEFITS	5	
48 CLINIC ADVERTISING	A	-9,495	CLINIC	60	
49 PHYSICIAN RECRUITING	A	-8,523	OTHER ADMINISTRATIVE AND	6.04	
49.01 CABLE TV	A	-3,261	OTHER ADMINISTRATIVE AND	6.04	
49.02 PROVIDER TAX IDPA EXPENSE	A	-315,759	OTHER ADMINISTRATIVE AND	6.04	
49.03 ILLINOIS HEALTH CARE CENTER	B	-10,213	OTHER ADMINISTRATIVE AND	6.04	
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,324,784			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	44	PATHOLOGY	30,000	15,000	15,000			
2	53	EKG	56,321	56,321				
3	61	EMERGENCY ROOM	1,303,650	712,994	590,656			
4	40	ANESTHESIOLOGY	650,575	650,575				
5	41	RADIOLOGY	850	850				
6	60	CLINIC	93,600	93,600				
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	2,134,996	1,529,340	605,656				

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	6
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	90
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	18
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	144.00			
10	AHSEA (SEE INSTRUCTIONS)	65.09			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.55	32.55		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	9,373
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	9,373
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	9,373

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	9,373

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

STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

STANDARD TRAVEL EXPENSE	
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)

PHYSICAL THERAPY

37 ASSISTANTS (LINE 6 TIMES COLUMN 3,
 LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37)
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
 LINES 5 AND 6)
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
 COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
 LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
 COLUMNS 1-3, LINE 13)
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 38 AND 39 -
 SEE INSTRUCTIONS)
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 39 AND 42 -
 SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 42 AND 43 -
 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
49 CALCULATION OF LIMIT TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
52 DETERMINATION OF OVERTIME ALLOWANCE ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART I, LINE 23)	9,373
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	9,373
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	6,480
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	6,480
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	6,480
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION-HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

PHYSICAL THERAPY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	120
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAI NEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	120.00			
10	AHSEA (SEE INSTRUCTIONS)	51.12			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	25.56	25.56		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	6,134
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	6,134
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAI NEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	6,134

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAI NEES (SEE INSTRUCTIONS)	51.12
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAI NEES (SEE INSTRUCTIONS)	39,874
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	39,874

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	3,067
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	3,067
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	3,067
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	3,067
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	

RESPIRATORY THERAPY

37 ASSISTANTS (LINE 6 TIMES COLUMN 3,
 LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37)
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
 LINES 5 AND 6)
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
 COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
 LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
 COLUMNS 1-3, LINE 13)
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 38 AND 39 -
 SEE INSTRUCTIONS)
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 39 AND 42 -
 SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 42 AND 43 -
 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
49 CALCULATION OF LIMIT TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
52 DETERMINATION OF OVERTIME ALLOWANCE ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART I, LINE 23)	39,874
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	3,067
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	42,941
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	37,075
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	37,075
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	37,075
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION-HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

RESPIRATORY THERAPY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	70
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	1,050
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	123
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAI NEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	981.50			
10	AHSEA (SEE INSTRUCTIONS)	61.70			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	30.85	30.85		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	60,559
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	60,559
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAI NEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	60,559

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAI NEES (SEE INSTRUCTIONS)	61.70
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAI NEES (SEE INSTRUCTIONS)	64,785
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	64,785

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	3,795
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	3,795
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	3,795
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	3,795
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	

OCCUPATIONAL THERAPY

37 ASSISTANTS (LINE 6 TIMES COLUMN 3,
 LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37)
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
 LINES 5 AND 6)
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
 COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
 LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
 COLUMNS 1-3, LINE 13)
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 38 AND 39 -
 SEE INSTRUCTIONS)
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 39 AND 42 -
 SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 42 AND 43 -
 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
49 CALCULATION OF LIMIT TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
52 DETERMINATION OF OVERTIME ALLOWANCE ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART I, LINE 23)	64,785
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	3,795
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	68,580
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	67,200
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	67,200
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	67,200
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION-HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

OCCUPATIONAL THERAPY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	9
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	135
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	12
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	93.00			
10	AHSEA (SEE INSTRUCTIONS)	59.29			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	29.65	29.65		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	5,514
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	5,514
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	5,514

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	59.29
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	8,004
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	8,004

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	356
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	356
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	356
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	356
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	

37 ASSISTANTS (LINE 6 TIMES COLUMN 3,
 LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37)
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
 LINES 5 AND 6)
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
 COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
 LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
 COLUMNS 1-3, LINE 13)
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 38 AND 39 -
 SEE INSTRUCTIONS)
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 39 AND 42 -
 SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 42 AND 43 -
 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
49 CALCULATION OF LIMIT TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
52 DETERMINATION OF OVERTIME ALLOWANCE ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART I, LINE 23)	8,004
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	356
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	8,360
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	7,440
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	7,440
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	7,440
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION-HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6.01	BUSINESS OFFICE	#	ACCUM	COST	NOT ENTERED
6.02	DATA PROCESSING	#	ACCUM	COST	NOT ENTERED
6.03	ADMITTING	-1	ACCUM	COST	ENTERED
6.04	OTHER ADMINISTRATIVE AND GENERAL	#	ACCUM	COST	NOT ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

COST CENTER DESCRIPTION		NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	BUSINESS OFFI CE	SUBTOTAL
		0	3	4	5	6a. 00	6. 01	6a. 01
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &	281,744	281,744					
004	NEW CAP REL COSTS-MVBLE E	923,229		923,229				
005	EMPLOYEE BENEFITS	2,977,524	552	1,808	2,979,884			
006 01	BUSINESS OFFICE	492,183	4,884	16,003	90,487	603,557	603,557	
006 02	DATA PROCESSING	557,942	3,523	11,545	82,757	655,767	18,102	673,869
006 03	ADMITTING	144,082	1,188	3,893	40,486	189,649	5,235	194,884
006 04	OTHER ADMINISTRATIVE AND	1,451,910	37,072	121,480	230,537	1,840,999	50,819	1,891,818
008	OPERATION OF PLANT	893,631	32,425	106,253	95,541	1,127,850	31,133	1,158,983
009	LAUNDRY & LINEN SERVICE	78,384	1,763	5,778		85,925	2,372	88,297
010	HOUSEKEEPING	341,013	2,897	9,493	85,236	438,639	12,108	450,747
011	DIETARY	195,205	10,424	34,157	36,609	276,395	7,630	284,025
012	CAFETERIA	212,513	5,388	17,655	44,527	280,083	7,731	287,814
017	MEDICAL RECORDS & LIBRARY	447,295	5,229	17,134	77,481	547,139	15,103	562,242
018	SOCIAL SERVICE	161,878	833	2,728	46,063	211,502	5,838	217,340
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	2,037,251	49,648	162,688	533,729	2,783,316	76,827	2,860,143
026	INTENSIVE CARE UNIT	518,547	8,112	26,583	125,374	678,616	18,733	697,349
026	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	604,991	22,743	74,525	112,114	814,373	22,480	836,853
038	RECOVERY ROOM	16,751	2,048	6,709	3,974	29,482	814	30,296
040	ANESTHESIOLOGY	56,107				56,107	1,549	57,656
041	RADIOLOGY-DIAGNOSTIC	1,814,227	16,759	54,918	146,056	2,031,960	56,090	2,088,050
044	LABORATORY	1,451,337	11,669	38,238	189,915	1,691,159	46,683	1,737,842
049	RESPIRATORY THERAPY	414,373	5,747	18,831	107,578	546,529	15,086	561,615
050	PHYSICAL THERAPY	239,731	7,442	24,387	61,190	332,750	9,185	341,935
051	OCCUPATIONAL THERAPY	98,222	1,405	4,602	5,120	109,349	3,018	112,367
052	SPEECH PATHOLOGY	7,440				7,440	205	7,645
053	ELECTROCARDIOLOGY	64,976			10,736	75,712	2,090	77,802
055	MEDICAL SUPPLIES CHARGED	345,371	12,918	42,330	15,398	416,017	11,484	427,501
056	DRUGS CHARGED TO PATIENTS	1,546,247	2,684	8,794	70,641	1,628,366	44,949	1,673,315
058	ASC (NON-DISTINCT PART)	102,624	10,288	33,714	24,003	170,629	4,710	175,339
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC	251,660	8,681	28,446	65,835	354,622	9,789	364,411
061	EMERGENCY	1,553,629	10,640	34,867	172,978	1,772,114	48,917	1,821,031
062	OBSERVATION BEDS (NON-DIS							
062	OTHER REIMBURS COST CNTRS							
071	HOME HEALTH AGENCY	343,615	4,061	13,308	87,028	448,012	12,367	460,379
071	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	20,625,632	281,023	920,867	2,561,393	20,204,058	541,047	20,141,548
095	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		721	2,362		3,083	85	3,168
098	PHYSICIANS' PRIVATE OFFIC	1,842,955			418,491	2,261,446	62,425	2,323,871
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	22,468,587	281,744	923,229	2,979,884	22,468,587	603,557	22,468,587

COST CENTER DESCRIPTION	DATA PROCESSING	SUBTOTAL	ADMINISTRATIVE	SUBTOTAL	OTHER ADMINISTRATIVE AND OPERATIONAL	PLANT	LAUNDRY & LINEN SERVICE
	6.02	6a.02	6.03	6a.03	6.04	8	9
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 BUSINESS OFFICE							
006 02 DATA PROCESSING	673,869	6a.02	6.03	6a.03	6.04	8	9
006 03 ADMINITTING	6,026	200,910	200,910				
006 04 OTHER ADMINISTRATIVE AND	58,493	1,950,311	19,718	1,970,029	1,970,029		
008 OPERATION OF PLANT	35,835	1,194,818	12,080	1,206,898	115,990	1,322,888	
009 LAUNDRY & LINEN SERVICE	2,730	91,027	920	91,947	8,837	11,542	112,326
010 HOUSEKEEPING	13,937	464,684	4,698	469,382	45,110	18,963	
011 DIETARY	8,782	292,807	2,960	295,767	28,425	68,231	
012 CAFETERIA	8,899	296,713	3,000	299,713	28,804	35,268	
017 MEDICAL RECORDS & LIBRARY	17,384	579,626	5,860	585,486	56,269	34,226	
018 SOCIAL SERVICE	6,720	224,060	2,265	226,325	21,751	5,450	
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	88,431	2,948,574	29,815	2,978,389	286,236	324,983	59,079
INTENSIVE CARE UNIT	21,561	718,910	7,268	726,178	69,790	53,101	5,519
037 ANCILLARY SRVC CNTRS							
038 OPERATING ROOM	25,875	862,728	8,722	871,450	83,752	148,868	8,913
038 RECOVERY ROOM	937	31,233	316	31,549	3,032	13,403	
040 ANESTHESIOLOGY	1,783	59,439	601	60,040	5,770		
041 RADIOLOGY-DIAGNOSTIC	64,560	2,152,610	21,763	2,174,373	208,970	109,702	7,505
044 LABORATORY	53,732	1,791,574	18,113	1,809,687	173,922	76,384	
049 RESPIRATORY THERAPY	17,365	578,980	5,853	584,833	56,206	37,616	861
050 PHYSICAL THERAPY	10,572	352,507	3,564	356,071	34,221	48,714	8,122
051 OCCUPATIONAL THERAPY	3,474	115,841	1,171	117,012	11,246	9,193	
052 SPEECH PATHOLOGY	236	7,881	80	7,961	765		
053 ELECTROCARDIOLOGY	2,406	80,208	811	81,019	7,786		
055 MEDICAL SUPPLIES CHARGED	13,218	440,719	4,456	445,175	42,784	84,558	113
056 DRUGS CHARGED TO PATIENTS	51,737	1,725,052	17,440	1,742,492	167,464	17,567	
058 ASC (NON-DISTINCT PART)	5,421	180,760	1,827	182,587	17,548	67,345	3,126
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	11,267	375,678	3,798	379,476	36,470	56,822	584
062 EMERGENCY	56,304	1,877,335	18,980	1,896,315	182,247	69,649	17,783
071 OBSERVATION BEDS (NON-DIS							
HOME REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY	14,234	474,613	4,798	479,411	46,074	26,584	
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	601,919	20,069,598	200,877	20,069,565	1,739,469	1,318,169	111,605
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	98	3,266	33	3,299	317	4,719	
098 PHYSICIANS' PRIVATE OFFIC	71,852	2,395,723		2,395,723	230,243		721
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	673,869	22,468,587	200,910	22,468,587	1,970,029	1,322,888	112,326

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ
	10	11	12	17	18	25	26
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 BUSINESS OFFICE							
006 02 DATA PROCESSING							
006 03 ADMITTING							
006 04 OTHER ADMINISTRATIVE AND OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	533,455						
011 DIETARY	6,560	398,983					
012 CAFETERIA			363,785				
017 MEDICAL RECORDS & LIBRARY	5,280		21,399	702,660			
018 SOCIAL SERVICE			7,133		260,659		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	178,406	361,670	109,373	204,236	230,813	4,733,185	
INTENSIVE CARE UNIT	20,641	25,510	19,021	19,662	7,710	947,132	
037 ANCILLARY SRVC COST CNTRS							
038 RECOVERY ROOM	57,922		16,644	41,781		1,229,330	
040 ANESTHESIOLOGY			2,378			50,362	
041 RADIOLOGY-DIAGNOSTIC	36,001		23,777	115,512		65,810	
044 LABORATORY	28,161		40,421	27,035		2,675,840	
049 RESPIRATORY THERAPY	13,760		19,021	14,501		2,155,610	
050 PHYSICAL THERAPY	13,600		9,511	3,932		726,798	
051 OCCUPATIONAL THERAPY				983		474,171	
052 SPEECH PATHOLOGY				983		138,434	
053 ELECTROCARDIOLOGY			2,378	15,484		9,709	
055 MEDICAL SUPPLIES CHARGED	4,960		4,755			106,667	
056 DRUGS CHARGED TO PATIENTS	5,440		7,133			582,345	
058 ASC (NON-DISTINCT PART)		11,803	4,755			1,940,096	
OUTPAT SERVICE COST CNTRS						298,854	
060 CLINIC	31,041		11,888	29,984		555,716	
061 EMERGENCY	51,521		30,910	163,438	9,451	2,411,863	
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)							
071 HOME HEALTH AGENCY	6,720				995	559,784	
095 SPEC PURPOSE COST CENTERS							
SUBTOTALS	460,013	398,983	330,497	637,531	260,659	19,661,706	
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP	73,442					81,777	
101 PHYSICIANS' PRIVATE OFFICE			33,288	65,129		2,725,104	
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	533,455	398,983	363,785	702,660	260,659	22,468,587	

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION		TOTAL
	GENERAL SERVICE COST CNTR	27
003	NEW CAP REL COSTS-BLDG &	
004	NEW CAP REL COSTS-MVBLE E	
005	EMPLOYEE BENEFITS	
006	01 BUSINESS OFFICE	
006	02 DATA PROCESSING	
006	03 ADMITTING	
006	04 OTHER ADMINISTRATIVE AND OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	4,733,185
026	INTENSIVE CARE UNIT	947,132
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	1,229,330
038	RECOVERY ROOM	50,362
040	ANESTHESIOLOGY	65,810
041	RADIOLOGY-DIAGNOSTIC	2,675,840
044	LABORATORY	2,155,610
049	RESPIRATORY THERAPY	726,798
050	PHYSICAL THERAPY	474,171
051	OCCUPATIONAL THERAPY	138,434
052	SPEECH PATHOLOGY	9,709
053	ELECTROCARDIOLOGY	106,667
055	MEDICAL SUPPLIES CHARGED	582,345
056	DRUGS CHARGED TO PATIENTS	1,940,096
058	ASC (NON-DISTINCT PART)	298,854
	OUTPAT SERVICE COST CNTRS	
060	CLINIC	555,716
061	EMERGENCY	2,411,863
062	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)	
071	HOME HEALTH AGENCY	559,784
	SPEC PURPOSE COST CENTERS	
095	SUBTOTALS	19,661,706
	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	81,777
098	PHYSICIANS' PRIVATE OFFICE	2,725,104
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	TOTAL	22,468,587

	COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	BUSINESS CE	OFFICE	DATA NG	PROCESSI NG
		0	3	4	4a	5		6.01		6.02
003	GENERAL SERVICE COST CNTR									
004	NEW CAP REL COSTS-BLDG &									
005	NEW CAP REL COSTS-MVBLE E									
005	EMPLOYEE BENEFITS		552	1,808	2,360	2,360				
006	01 BUSINESS OFFICE		4,884	16,003	20,887	72		20,959		
006	02 DATA PROCESSING		3,523	11,545	15,068	66		629		15,763
006	03 ADMITTING		1,188	3,893	5,081	32		182		141
006	04 OTHER ADMINISTRATIVE AND		37,072	121,480	158,552	183		1,766		1,368
008	OPERATION OF PLANT		32,425	106,253	138,678	76		1,082		838
009	LAUNDRY & LINEN SERVICE		1,763	5,778	7,541			82		64
010	HOUSEKEEPING		2,897	9,493	12,390		68	421		326
011	DIETARY		10,424	34,157	44,581		29	265		205
012	CAFETERIA		5,388	17,655	23,043		35	269		208
017	MEDICAL RECORDS & LIBRARY		5,229	17,134	22,363		61	525		407
018	SOCIAL SERVICE		833	2,728	3,561		36	203		157
025	INPAT ROUTINE SRVC CNTRS									
025	ADULTS & PEDIATRICS		49,648	162,688	212,336		423	2,656		2,073
026	INTENSIVE CARE UNIT		8,112	26,583	34,695		99	651		504
026	ANCILLARY SRVC COST CNTRS									
037	OPERATING ROOM		22,743	74,525	97,268		89	781		605
038	RECOVERY ROOM		2,048	6,709	8,757		3	28		22
040	ANESTHESIOLOGY							54		42
041	RADIOLOGY-DIAGNOSTIC		16,759	54,918	71,677		116	1,949		1,510
044	LABORATORY		11,669	38,238	49,907		150	1,622		1,256
049	RESPIRATORY THERAPY		5,747	18,831	24,578		85	524		406
050	PHYSICAL THERAPY		7,442	24,387	31,829		48	319		247
051	OCCUPATIONAL THERAPY		1,405	4,602	6,007		4	105		81
052	SPEECH PATHOLOGY							7		6
053	ELECTROCARDIOLOGY							9		56
055	MEDICAL SUPPLIES CHARGED		12,918	42,330	55,248		12	399		309
056	DRUGS CHARGED TO PATIENTS		2,684	8,794	11,478		56	1,562		1,210
058	ASC (NON-DISTINCT PART)		10,288	33,714	44,002		19	164		127
060	OUTPAT SERVICE COST CNTRS									
060	CLINIC		8,681	28,446	37,127		52	340		263
061	EMERGENCY		10,640	34,867	45,507		137	1,699		1,317
062	OBSERVATION BEDS (NON-DIS									
062	OTHER REIMBURS COST CNTRS									
071	HOME HEALTH AGENCY		4,061	13,308	17,369		69	430		333
071	SPEC PURPOSE COST CENTERS									
095	SUBTOTALS		281,023	920,867	1,201,890		2,029	18,787		14,081
095	NONREIMBURS COST CENTERS									
096	GIFT, FLOWER, COFFEE SHOP		721	2,362	3,083			3		2
098	PHYSICIANS' PRIVATE OFFIC	74,647			74,647		331	2,169		1,680
101	CROSS FOOT ADJUSTMENTS									
102	NEGATIVE COST CENTER									
103	TOTAL	74,647	281,744	923,229	1,279,620		2,360	20,959		15,763

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	ADMITTING	OTHER ADMINISTRATIVE AND	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	6.03	6.04	8	9	10	11	12
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 BUSINESS OFFICE							
006 02 DATA PROCESSING							
006 03 ADMITTING	5,436						
006 04 OTHER ADMINISTRATIVE AND	534	162,403					
008 OPERATION OF PLANT	327	9,562	150,563				
009 LAUNDRY & LINEN SERVICE	25	728	1,314	9,754			
010 HOUSEKEEPING	127	3,719	2,158		19,209		
011 DIETARY	80	2,343	7,766		236	55,505	
012 CAFETERIA	81	2,375	4,014				30,025
017 MEDICAL RECORDS & LIBRARY	159	4,639	3,895		190		1,766
018 SOCIAL SERVICE	61	1,793	620				589
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	799	23,590	36,988	5,130	6,424	50,314	9,029
INTENSIVE CARE UNIT	197	5,754	6,044	479	743	3,549	1,570
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	236	6,904	16,943	774	2,086		1,374
038 RECOVERY ROOM	9	250	1,525				196
040 ANESTHESIOLOGY	16	476					
041 RADIOLOGY-DIAGNOSTIC	590	17,228	12,486	652	1,296		1,962
044 LABORATORY	491	14,338	8,694		1,014		3,336
049 RESPIRATORY THERAPY	159	4,634	4,281		495		1,570
050 PHYSICAL THERAPY	97	2,821	5,544	705	490		785
051 OCCUPATIONAL THERAPY	32	927	1,046				
052 SPEECH PATHOLOGY	2	63					
053 ELECTROCARDIOLOGY	22	642					196
055 MEDICAL SUPPLIES CHARGED	121	3,527	9,624	10	179		392
056 DRUGS CHARGED TO PATIENTS	473	13,806	1,999		196		589
058 ASC (NON-DISTINCT PART)	50	1,447	7,665	271		1,642	392
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	103	3,007	6,467	51	1,118		981
062 EMERGENCY	514	15,025	7,927	1,544	1,855		2,551
071 OBSERVATION BEDS (NON-DIS							
HOME HEALTH AGENCY	130	3,798	3,026		242		
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	5,435	143,396	150,026	9,691	16,564	55,505	27,278
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	1	26	537		2,645		
098 PHYSICIANS' PRIVATE OFFIC		18,981		63			2,747
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	5,436	162,403	150,563	9,754	19,209	55,505	30,025

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	BUSINESS OFFI	RECONCILIATION
	OSTS-BLDG &	OSTS-MVBLE E	FITS		CE	
	(FEET)	(FEET)	(GROSS SALARIES)		(ACCUM COST)	
	3	4	5	6a. 01	6. 01	6a. 02
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	83,249					
005 NEW CAP REL COSTS-MVB		83,249				
006 01 EMPLOYEE BENEFITS	163	163	10,305,379			
006 02 BUSINESS OFFICE	1,443	1,443	312,933	-603,557	21,865,030	
006 03 DATA PROCESSING	1,041	1,041	286,199		655,767	-673,869
006 04 ADMITTING	351	351	140,014		189,649	
006 04 OTHER ADMINISTRATIVE	10,954	10,954	797,270		1,840,999	
008 OPERATION OF PLANT	9,581	9,581	330,412		1,127,850	
009 LAUNDRY & LINEN SERVI	521	521			85,925	
010 HOUSEKEEPING	856	856	294,774		438,639	
011 DIETARY	3,080	3,080	126,606		276,395	
012 CAFETERIA	1,592	1,592	153,989		280,083	
017 MEDICAL RECORDS & LIB	1,545	1,545	267,954		547,139	
018 SOCIAL SERVICE	246	246	159,300		211,502	
025 INPAT ROUTINE SRVC CN	14,670	14,670	1,845,797		2,783,316	
026 ADULTS & PEDIATRICS	2,397	2,397	433,583		678,616	
037 INTENSIVE CARE UNIT						
038 ANCILLARY SRVC COST C	6,720	6,720	387,725		814,373	
040 OPERATING ROOM	605	605	13,743		29,482	
041 RECOVERY ROOM					56,107	
044 ANESTHESIOLOGY	4,952	4,952	505,108		2,031,960	
049 LABORATORY	3,448	3,448	656,785		1,691,159	
050 RESPIRATORY THERAPY	1,698	1,698	372,040		546,529	
051 PHYSICAL THERAPY	2,199	2,199	211,615		332,750	
052 OCCUPATIONAL THERAPY	415	415	17,708		109,349	
053 SPEECH PATHOLOGY					7,440	
055 ELECTROCARDIOLOGY			37,128		75,712	
056 MEDICAL SUPPLIES CHAR	3,817	3,817	53,251		416,017	
058 DRUGS CHARGED TO PATI	793	793	244,298		1,628,366	
060 ASC (NON-DISTINCT PAR	3,040	3,040	83,010		170,629	
061 OUTPAT SERVICE COST C						
062 CLINIC	2,565	2,565	227,678		354,622	
071 EMERGENCY	3,144	3,144	598,214		1,772,114	
095 OBSERVATION BEDS (NON						
096 OTHER REIMBURS COST C	1,200	1,200	300,972		448,012	
099 HOME HEALTH AGENCY						
101 SPEC PURPOSE COST CEN	83,036	83,036	8,858,106	-603,557	19,600,501	-673,869
102 SUBTOTALS						
103 NONREIMBURS COST CENT	213	213			3,083	
104 GIFT, FLOWER, COFFEE			1,447,273		2,261,446	
105 PHYSICIANS' PRIVATE O						
106 CROSS FOOT ADJUSTMENT						
107 NEGATIVE COST CENTER						
108 COST TO BE ALLOCATED	281,744	923,229	2,979,884		603,557	
(WRKSHT B, PART I)						
UNIT COST MULTIPLIER	3.384353		.289158		.027604	
(WRKSHT B, PT I)		11.089971				
COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
COST TO BE ALLOCATED			2,360		20,959	
(WRKSHT B, PART III)						
UNIT COST MULTIPLIER			.000229		.000959	
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	DATA PROCESSING		ADMITTING		OTHER ADMINISTRATIVE AND	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
		(ACCUM COST)	RECONCILIATION	(ACCUM COST)	RECONCILIATION	(ACCUM COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)
		6.02	6a.03	6.03	6a.04	6.04	8	9
003	GENERAL SERVICE COST							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
006 01	BUSINESS OFFICE							
006 02	DATA PROCESSING	21,794,718						
006 03	ADMITTING	194,884	-200,910	19,871,954				
006 04	OTHER ADMINISTRATIVE	1,891,818		1,950,311	-1,970,029	20,498,558		
008	OPERATION OF PLANT	1,158,983		1,194,818		1,206,898	59,716	
009	LAUNDRY & LINEN SERV	88,297		91,027		91,947	521	156,463
010	HOUSEKEEPING	450,747		464,684		469,382	856	
011	DIETARY	284,025		292,807		295,767	3,080	
012	CAFETERIA	287,814		296,713		299,713	1,592	
017	MEDICAL RECORDS & LIB	562,242		579,626		585,486	1,545	
018	SOCIAL SERVICE	217,340		224,060		226,325	246	
025	INPAT ROUTINE SRVC CN							
026	ADULTS & PEDIATRICS	2,860,143		2,948,574		2,978,389	14,670	82,293
	INTENSIVE CARE UNIT	697,349		718,910		726,178	2,397	7,687
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	836,853		862,728		871,450	6,720	12,415
038	RECOVERY ROOM	30,296		31,233		31,549	605	
040	ANESTHESIOLOGY	57,656		59,439		60,040		
041	RADIOLOGY-DIAGNOSTIC	2,088,050		2,152,610		2,174,373	4,952	10,454
044	LABORATORY	1,737,842		1,791,574		1,809,687	3,448	
049	RESPIRATORY THERAPY	561,615		578,980		584,833	1,698	1,200
050	PHYSICAL THERAPY	341,935		352,507		356,071	2,199	11,313
051	OCCUPATIONAL THERAPY	112,367		115,841		117,012	415	
052	SPEECH PATHOLOGY	7,645		7,881		7,961		
053	ELECTROCARDIOLOGY	77,802		80,208		81,019		
055	MEDICAL SUPPLIES CHAR	427,501		440,719		445,175	3,817	157
056	DRUGS CHARGED TO PATI	1,673,315		1,725,052		1,742,492	793	
058	ASC (NON-DISTINCT PAR	175,339		180,760		182,587	3,040	4,354
	OUTPAT SERVICE COST C							
060	CLINIC	364,411		375,678		379,476	2,565	814
061	EMERGENCY	1,821,031		1,877,335		1,896,315	3,144	24,771
062	OBSERVATION BEDS (NON							
	OTHER REIMBURS COST C							
071	HOME HEALTH AGENCY	460,379		474,613		479,411	1,200	
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	19,467,679	-200,910	19,868,688	-1,970,029	18,099,536	59,503	155,458
096	NONREIMBURS COST CENT							
	GIFT, FLOWER, COFFEE	3,168		3,266		3,299	213	
098	PHYSICIANS' PRIVATE O	2,323,871	-2,395,723			2,395,723		1,005
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	673,869		200,910		1,970,029	1,322,888	112,326
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER						22.152991	
	(WRKSHT B, PT I)	.030919		.010110		.096106		.717908
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	15,763		5,436		162,403	150,563	9,754
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER						2.521318	
	(WRKSHT B, PT III)	.000723		.000274		.007923		.062341

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
	(HOURS OF SERVICE)	(MEALS SERVED)	(FTE'S)	(TIME SPENT)	(TIME SPENT)
	10	11	12	17	18
003 GENERAL SERVICE COST					
004 NEW CAP REL COSTS-BLD					
005 NEW CAP REL COSTS-MVB					
006 EMPLOYEE BENEFITS					
006 01 BUSINESS OFFICE					
006 02 DATA PROCESSING					
006 03 ADMITTING					
006 04 OTHER ADMINISTRATIVE					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVI					
010 HOUSEKEEPING	3,334				
011 DIETARY	41	16,970			
012 CAFETERIA			153		
017 MEDICAL RECORDS & LIB	33		9	2,859	
018 SOCIAL SERVICE			3		1,048
025 INPAT ROUTINE SRVC CN	1,115	15,383	46	831	928
026 INTENSIVE CARE UNIT	129	1,085	8	80	31
037 ANCILLARY SRVC COST C					
038 OPERATING ROOM	362		7	170	
040 RECOVERY ROOM			1		
041 ANESTHESIOLOGY					
044 RADIOLOGY-DIAGNOSTIC	225		10	470	
049 LABORATORY	176		17	110	
050 RESPIRATORY THERAPY	86		8	59	
051 PHYSICAL THERAPY	85		4	16	
052 OCCUPATIONAL THERAPY				4	
053 SPEECH PATHOLOGY				4	
055 ELECTROCARDIOLOGY			1	63	
056 MEDICAL SUPPLIES CHAR	31		2		
058 DRUGS CHARGED TO PATI	34		3		
060 ASC (NON-DISTINCT PAR		502	2		47
061 OUTPAT SERVICE COST C					
062 CLINIC	194		5	122	38
066 EMERGENCY	322		13	665	
071 OBSERVATION BEDS (NON					
095 OTHER REIMBURS COST C					
096 HOME HEALTH AGENCY	42				4
098 SPEC PURPOSE COST CEN					
101 SUBTOTALS	2,875	16,970	139	2,594	1,048
102 NONREIMBURS COST CENT					
103 GIFT, FLOWER, COFFEE	459				
104 PHYSICIANS' PRIVATE O			14	265	
105 CROSS FOOT ADJUSTMENT					
106 NEGATIVE COST CENTER					
107 COST TO BE ALLOCATED	533,455	398,983	363,785	702,660	260,659
108 (PER WRKSHT B, PART					
UNIT COST MULTIPLIER		23.511078		245.771249	
(WRKSHT B, PT I)	160.004499		2,377.679739		248.720420
105 COST TO BE ALLOCATED					
106 (PER WRKSHT B, PART					
UNIT COST MULTIPLIER					
(WRKSHT B, PT II)					
107 COST TO BE ALLOCATED	19,209	55,505	30,025	34,005	7,020
108 (PER WRKSHT B, PART					
UNIT COST MULTIPLIER		3.270772		11.894019	
(WRKSHT B, PT III)	5.761548		196.241830		6.698473

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
26	ADULTS & PEDIATRICS	4,733,185		4,733,185		
	INTENSIVE CARE UNIT	947,132		947,132		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,229,330		1,229,330		
38	RECOVERY ROOM	50,362		50,362		
40	ANESTHESIOLOGY	65,810		65,810		
41	RADIOLOGY-DIAGNOSTIC	2,675,840		2,675,840		
44	LABORATORY	2,155,610		2,155,610		
49	RESPIRATORY THERAPY	726,798		726,798		
50	PHYSICAL THERAPY	474,171		474,171		
51	OCCUPATIONAL THERAPY	138,434		138,434		
52	SPEECH PATHOLOGY	9,709		9,709		
53	ELECTROCARDIOLOGY	106,667		106,667		
55	MEDICAL SUPPLIES CHARGED	582,345		582,345		
56	DRUGS CHARGED TO PATIENTS	1,940,096		1,940,096		
58	ASC (NON-DISTINCT PART)	298,854		298,854		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	555,716		555,716		
61	EMERGENCY	2,411,863		2,411,863		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	483,438		483,438		
101	SUBTOTAL	19,585,360		19,585,360		
102	LESS OBSERVATION BEDS	483,438		483,438		
103	TOTAL	19,101,922		19,101,922		

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	3,487,335		3,487,335			
26	INTENSIVE CARE UNIT	620,810		620,810			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	461,948	1,074,653	1,536,601	.800032	.800032	
38	RECOVERY ROOM	57,442	89,962	147,404	.341660	.341660	
40	ANESTHESIOLOGY	80,270	212,665	292,935	.224657	.224657	
41	RADIOLOGY-DIAGNOSTIC	1,515,317	8,975,613	10,490,930	.255062	.255062	
44	LABORATORY	1,859,664	6,117,713	7,977,377	.270215	.270215	
49	RESPIRATORY THERAPY	871,942	242,959	1,114,901	.651895	.651895	
50	PHYSICAL THERAPY	315,740	948,559	1,264,299	.375047	.375047	
51	OCCUPATIONAL THERAPY	51,414	126,004	177,418	.780270	.780270	
52	SPEECH PATHOLOGY	3,000	3,910	6,910	1.405065	1.405065	
53	ELECTROCARDIOLOGY	186,145	938,471	1,124,616	.094847	.094847	
55	MEDICAL SUPPLIES CHARGED	1,733,494	570,723	2,304,217	.252730	.252730	
56	DRUGS CHARGED TO PATIENTS	1,565,782	3,401,687	4,967,469	.390560	.390560	
58	ASC (NON-DISTINCT PART)	5,968	325,765	331,733	.900887	.900887	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	4,470	520,604	525,074	1.058357	1.058357	
61	EMERGENCY	217,929	3,146,613	3,364,542	.716847	.716847	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	35,417	398,361	433,778	1.114483	1.114483	
101	SUBTOTAL	13,074,087	27,094,262	40,168,349			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,074,087	27,094,262	40,168,349			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS					
26	ADULTS & PEDIATRICS	4,733,185		4,733,185		
	INTENSIVE CARE UNIT	947,132		947,132		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,229,330		1,229,330		
38	RECOVERY ROOM	50,362		50,362		
40	ANESTHESIOLOGY	65,810		65,810		
41	RADIOLOGY-DIAGNOSTIC	2,675,840		2,675,840		
44	LABORATORY	2,155,610		2,155,610		
49	RESPIRATORY THERAPY	726,798		726,798		
50	PHYSICAL THERAPY	474,171		474,171		
51	OCCUPATIONAL THERAPY	138,434		138,434		
52	SPEECH PATHOLOGY	9,709		9,709		
53	ELECTROCARDIOLOGY	106,667		106,667		
55	MEDICAL SUPPLIES CHARGED	582,345		582,345		
56	DRUGS CHARGED TO PATIENTS	1,940,096		1,940,096		
58	ASC (NON-DISTINCT PART)	298,854		298,854		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	555,716		555,716		
61	EMERGENCY	2,411,863		2,411,863		
62	OBSERVATION BEDS (NON-DIS)	483,438		483,438		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	19,585,360		19,585,360		
102	LESS OBSERVATION BEDS	483,438		483,438		
103	TOTAL	19,101,922		19,101,922		

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	3,487,335		3,487,335			
	INTENSIVE CARE UNIT	620,810		620,810			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	461,948	1,074,653	1,536,601	.800032	.800032	
38	RECOVERY ROOM	57,442	89,962	147,404	.341660	.341660	
40	ANESTHESIOLOGY	80,270	212,665	292,935	.224657	.224657	
41	RADIOLOGY-DIAGNOSTIC	1,515,317	8,975,613	10,490,930	.255062	.255062	
44	LABORATORY	1,859,664	6,117,713	7,977,377	.270215	.270215	
49	RESPIRATORY THERAPY	871,942	242,959	1,114,901	.651895	.651895	
50	PHYSICAL THERAPY	315,740	948,559	1,264,299	.375047	.375047	
51	OCCUPATIONAL THERAPY	51,414	126,004	177,418	.780270	.780270	
52	SPEECH PATHOLOGY	3,000	3,910	6,910	1.405065	1.405065	
53	ELECTROCARDIOLOGY	186,145	938,471	1,124,616	.094847	.094847	
55	MEDICAL SUPPLIES CHARGED	1,733,494	570,723	2,304,217	.252730	.252730	
56	DRUGS CHARGED TO PATIENTS	1,565,782	3,401,687	4,967,469	.390560	.390560	
58	ASC (NON-DISTINCT PART)	5,968	325,765	331,733	.900887	.900887	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	4,470	520,604	525,074	1.058357	1.058357	
61	EMERGENCY	217,929	3,146,613	3,364,542	.716847	.716847	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	35,417	398,361	433,778	1.114483	1.114483	
101	SUBTOTAL	13,074,087	27,094,262	40,168,349			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,074,087	27,094,262	40,168,349			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,229,330	129,082	1,100,248			1,229,330
38	RECOVERY ROOM	50,362	10,790	39,572			50,362
40	ANESTHESIOLOGY	65,810	588	65,222			65,810
41	RADIOLOGY-DIAGNOSTIC	2,675,840	115,056	2,560,784			2,675,840
44	LABORATORY	2,155,610	82,116	2,073,494			2,155,610
49	RESPIRATORY THERAPY	726,798	37,509	689,289			726,798
50	PHYSICAL THERAPY	474,171	43,075	431,096			474,171
51	OCCUPATIONAL THERAPY	138,434	8,250	130,184			138,434
52	SPEECH PATHOLOGY	9,709	126	9,583			9,709
53	ELECTROCARDIOLOGY	106,667	1,747	104,920			106,667
55	MEDICAL SUPPLIES CHARGED	582,345	69,821	512,524			582,345
56	DRUGS CHARGED TO PATIENTS	1,940,096	31,369	1,908,727			1,940,096
58	ASC (NON-DISTINCT PART)	298,854	56,094	242,760			298,854
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	555,716	51,215	504,501			555,716
61	EMERGENCY	2,411,863	85,986	2,325,877			2,411,863
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	483,438		483,438			483,438
101	SUBTOTAL	13,905,043	722,824	13,182,219			13,905,043
102	LESS OBSERVATION BEDS	483,438		483,438			483,438
103	TOTAL	13,421,605	722,824	12,698,781			13,421,605

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1,536,601	.800032	.800032
38	RECOVERY ROOM	147,404	.341660	.341660
40	ANESTHESIOLOGY	292,935	.224657	.224657
41	RADIOLOGY-DIAGNOSTIC	10,490,930	.255062	.255062
44	LABORATORY	7,977,377	.270215	.270215
49	RESPIRATORY THERAPY	1,114,901	.651895	.651895
50	PHYSICAL THERAPY	1,264,299	.375047	.375047
51	OCCUPATIONAL THERAPY	177,418	.780270	.780270
52	SPEECH PATHOLOGY	6,910	1.405065	1.405065
53	ELECTROCARDIOLOGY	1,124,616	.094847	.094847
55	MEDICAL SUPPLIES CHARGED	2,304,217	.252730	.252730
56	DRUGS CHARGED TO PATIENTS	4,967,469	.390560	.390560
58	ASC (NON-DISTINCT PART)	331,733	.900887	.900887
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	525,074	1.058357	1.058357
61	EMERGENCY	3,364,542	.716847	.716847
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	433,778	1.114483	1.114483
101	SUBTOTAL	36,060,204		
102	LESS OBSERVATION BEDS	433,778		
103	TOTAL	35,626,426		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,229,330	129,082	1,100,248			1,229,330
38	RECOVERY ROOM	50,362	10,790	39,572			50,362
40	ANESTHESIOLOGY	65,810	588	65,222			65,810
41	RADIOLOGY-DIAGNOSTIC	2,675,840	115,056	2,560,784			2,675,840
44	LABORATORY	2,155,610	82,116	2,073,494			2,155,610
49	RESPIRATORY THERAPY	726,798	37,509	689,289			726,798
50	PHYSICAL THERAPY	474,171	43,075	431,096			474,171
51	OCCUPATIONAL THERAPY	138,434	8,250	130,184			138,434
52	SPEECH PATHOLOGY	9,709	126	9,583			9,709
53	ELECTROCARDIOLOGY	106,667	1,747	104,920			106,667
55	MEDICAL SUPPLIES CHARGED	582,345	69,821	512,524			582,345
56	DRUGS CHARGED TO PATIENTS	1,940,096	31,369	1,908,727			1,940,096
58	ASC (NON-DISTINCT PART)	298,854	56,094	242,760			298,854
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	555,716	51,215	504,501			555,716
61	EMERGENCY	2,411,863	85,986	2,325,877			2,411,863
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	483,438		483,438			483,438
101	SUBTOTAL	13,905,043	722,824	13,182,219			13,905,043
102	LESS OBSERVATION BEDS	483,438		483,438			483,438
103	TOTAL	13,421,605	722,824	12,698,781			13,421,605

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	1,536,601	.800032	.800032
38	RECOVERY ROOM	147,404	.341660	.341660
40	ANESTHESIOLOGY	292,935	.224657	.224657
41	RADIOLOGY-DIAGNOSTIC	10,490,930	.255062	.255062
44	LABORATORY	7,977,377	.270215	.270215
49	RESPIRATORY THERAPY	1,114,901	.651895	.651895
50	PHYSICAL THERAPY	1,264,299	.375047	.375047
51	OCCUPATIONAL THERAPY	177,418	.780270	.780270
52	SPEECH PATHOLOGY	6,910	1.405065	1.405065
53	ELECTROCARDIOLOGY	1,124,616	.094847	.094847
55	MEDICAL SUPPLIES CHARGED	2,304,217	.252730	.252730
56	DRUGS CHARGED TO PATIENTS	4,967,469	.390560	.390560
58	ASC (NON-DISTINCT PART)	331,733	.900887	.900887
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	525,074	1.058357	1.058357
61	EMERGENCY	3,364,542	.716847	.716847
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	433,778	1.114483	1.114483
101	SUBTOTAL	36,060,204		
102	LESS OBSERVATION BEDS	433,778		
103	TOTAL	35,626,426		

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.800032		.800032		
38 RECOVERY ROOM	.341660		.341660		
40 ANESTHESIOLOGY	.224657		.224657		
41 RADIOLOGY-DIAGNOSTIC	.255062		.255062		
44 LABORATORY	.270215		.270215		
49 RESPIRATORY THERAPY	.651895		.651895		
50 PHYSICAL THERAPY	.375047		.375047		
51 OCCUPATIONAL THERAPY	.780270		.780270		
52 SPEECH PATHOLOGY	1.405065		1.405065		
53 ELECTROCARDIOLOGY	.094847		.094847		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.252730		.252730		
56 DRUGS CHARGED TO PATIENTS	.390560		.390560		
58 ASC (NON-DISTINCT PART)	.900887		.900887		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.058357		1.058357		
61 EMERGENCY	.716847		.716847		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.114483		1.114483		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		472,030			
38 RECOVERY ROOM		38,961			
40 ANESTHESIOLOGY		90,595			
41 RADIOLOGY-DIAGNOSTIC		3,448,049			
44 LABORATORY		2,478,744			
49 RESPIRATORY THERAPY		87,885			
50 PHYSICAL THERAPY		297,468			
51 OCCUPATIONAL THERAPY		19,678			
52 SPEECH PATHOLOGY		422			
53 ELECTROCARDIOLOGY		417,855			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		240,780			
56 DRUGS CHARGED TO PATIENTS		2,024,401			
58 ASC (NON-DISTINCT PART)		143,249			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		302,064			
61 EMERGENCY		929,908			
62 OBSERVATION BEDS (NON-DISTINCT PART)		205,421			
101 SUBTOTAL		11,197,510			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		11,197,510			

(A) WORKSHEET A LINE NUMBERS
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B

HOSPITAL

All Other Hospital I/P Hospital I/P
 Part B Charges Part B Costs

Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM			
38 RECOVERY ROOM	377,639		
40 ANESTHESIOLOGY	13,311		
41 RADIOLOGY-DIAGNOSTIC	20,353		
44 LABORATORY	879,466		
49 RESPIRATORY THERAPY	669,794		
50 PHYSICAL THERAPY	57,292		
51 OCCUPATIONAL THERAPY	111,564		
52 SPEECH PATHOLOGY	15,354		
53 ELECTROCARDIOLOGY	593		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,632		
56 DRUGS CHARGED TO PATIENTS	60,852		
58 ASC (NON-DISTINCT PART)	790,650		
OUTPAT SERVICE COST CNTRS	129,051		
60 CLINIC		319,692	
61 EMERGENCY		666,602	
62 OBSERVATION BEDS (NON-DISTINCT PART)		228,938	
101 SUBTOTAL	4,380,783		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104 NET CHARGES	4,380,783		

(A) WORKSHEET A LINE NUMBERS
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.390560
2	PROGRAM VACCINE CHARGES		16,290
3	PROGRAM COSTS		6,362

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,812
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,501
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,501
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	920
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	320
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	51
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	20
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,312
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	920
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)	320
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	105.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	105.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	4,733,185
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	5,355
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	2,100
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,243,462
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,489,723

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,022,611
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,022,611
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.154539
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	863.36
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,489,723

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					996.78
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,304,555
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					2,304,555

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	947,132	390	2,428.54	246	597,421
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				

1
 1,803,615
 4,705,591

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	917,038
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	318,970
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	1,236,008
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	485
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	996.78
85	OBSERVATION BED COST	483,438

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			1,921,756	
26	INTENSIVE CARE UNIT			398,396	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM		.800032	261,315	209,060
38	RECOVERY ROOM		.341660	32,759	11,192
40	ANESTHESIOLOGY		.224657	41,710	9,370
41	RADIOLOGY-DIAGNOSTIC		.255062	863,036	220,128
44	LABORATORY		.270215	1,103,376	298,149
49	RESPIRATORY THERAPY		.651895	531,904	346,746
50	PHYSICAL THERAPY		.375047	110,852	41,575
51	OCCUPATIONAL THERAPY		.780270	11,106	8,666
52	SPEECH PATHOLOGY		1.405065	1,800	2,529
53	ELECTROCARDIOLOGY		.094847	114,201	10,832
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.252730	1,143,729	289,055
56	DRUGS CHARGED TO PATIENTS		.390560	896,315	350,065
58	ASC (NON-DISTINCT PART)		.900887	1,078	971
60	OUTPAT SERVICE COST CNTRS CLINIC		1.058357	3,980	4,212
61	EMERGENCY		.716847	1,485	1,065
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS		1.114483		
101	TOTAL			5,118,646	1,803,615
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			5,118,646	

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	OTHER	
			INPATIENT CHARGES 2	INPATIENT COST 3
	TITLE XVIII, PART A			
	SWING BED SNF			
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.800032	1,816	1,453
38	RECOVERY ROOM	.341660		
40	ANESTHESIOLOGY	.224657	810	182
41	RADIOLOGY-DIAGNOSTIC	.255062	33,561	8,560
44	LABORATORY	.270215	183,666	49,629
49	RESPIRATORY THERAPY	.651895	189,050	123,241
50	PHYSICAL THERAPY	.375047	181,549	68,089
51	OCCUPATIONAL THERAPY	.780270	36,683	28,623
52	SPEECH PATHOLOGY	1.405065	617	867
53	ELECTROCARDIOLOGY	.094847	3,399	322
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.252730	202,350	51,140
56	DRUGS CHARGED TO PATIENTS	.390560	222,523	86,909
58	ASC (NON-DISTINCT PART)	.900887	69	62
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.058357	96	102
61	EMERGENCY	.716847		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.114483		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,056,189	419,179
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,056,189	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,387,145
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,387,145
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,431,016
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	28,598
18.01	CAH ACTUAL BILLED COINSURANCE	1,773,673
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,628,745
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,628,745
24	PRIMARY PAYER PAYMENTS	2,234
25	SUBTOTAL	2,626,511
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	264,250
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	264,250
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	264,250
28	SUBTOTAL	2,890,761
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	2,218
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,888,543
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,637,237
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	251,306
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2	61,796

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT- PART A		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,987,452		2,637,237
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.		NONE		NONE
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. (1)				
ADJUSTMENTS TO PROVIDER .01	3/26/2008	350,000		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		350,000		NONE
4 TOTAL INTERIM PAYMENTS		4,337,452		2,637,237
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT- PART A		PART B	
	MM/DD/YYYY ¹	AMOUNT ²	MM/DD/YYYY ³	AMOUNT ⁴
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,359,069		NONE
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.		NONE		NONE
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. (1)				
ADJUSTMENTS TO PROVIDER .01	3/26/2008	225,000		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		225,000		NONE
4 TOTAL INTERIM PAYMENTS		1,584,069		NONE
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,248,368	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	423,371	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS		1,240
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,671,739	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,671,739	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,671,739	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	12,428	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,659,311	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,659,311	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,584,069	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	75,242	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11, SECTION 115.2.	23,179	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	4,705,591
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,705,591
5	PRIMARY PAYER PAYMENTS	2,540
6	TOTAL COST FOR CAH (SEE INSTRUCTIONS)	4,750,082

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
8	ROUTINE SERVICE CHARGES	
9	ANCILLARY SERVICE CHARGES	
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
11	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
13	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
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)	
15	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	4,750,082
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	474,818
21	EXCESS REASONABLE COST	
22	SUBTOTAL	4,275,264
23	COINSURANCE	6,155
24	SUBTOTAL	4,269,109
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	54,576
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	54,576
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	54,576
26	SUBTOTAL	4,323,685
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	4,323,685
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	4,337,452
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-13,767
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	65,957

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,476,392			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,044,672			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	333,283			
8	PREPAID EXPENSES	266,174			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	6,120,521			
FIXED ASSETS					
12	LAND	7,788			
12.01	LAND IMPROVEMENTS	454,820			
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	-331,089			
14	LEASEHOLD IMPROVEMENTS	8,992,769			
14.01	LESS ACCUMULATED DEPRECIATION	-5,470,257			
15	FIXED EQUIPMENT	10,694,721			
15.01	LESS ACCUMULATED DEPRECIATION	-7,926,837			
16	AUTOMOBILES AND TRUCKS				
16.01	LESS ACCUMULATED DEPRECIATION				
17	MAJOR MOVABLE EQUIPMENT				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MINOR EQUIPMENT DEPRECIABLE				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT-NONDEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	TOTAL FIXED ASSETS	6,421,915			
OTHER ASSETS					
21	INVESTMENTS	7,870,246			
22	DEPOSITS ON LEASES				
23	DUE FROM OWNERS/OFFICERS				
24	OTHER ASSETS				
25	TOTAL OTHER ASSETS	7,870,246			
26	TOTAL ASSETS	20,412,682			
27					

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	473,205			
29 SALARIES, WAGES & FEES PAYABLE	1,083,011			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)				
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	-183,729			
35 OTHER CURRENT LIABILITIES	213,451			
36 TOTAL CURRENT LIABILITIES	1,585,938			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	16,395			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	16,395			
43 TOTAL LIABILITIES	1,602,333			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	18,810,349			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	18,810,349			
52 TOTAL LIABILITIES AND FUND BALANCES	20,412,682			

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		18,853,255		
2 OF PERIOD				
3 NET INCOME (LOSS)		-42,906		
4 TOTAL		18,810,349		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		18,810,349		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		18,810,349		

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

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,022,611		3,022,611
4 00 SWING BED - SNF	864,035		864,035
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,886,646		3,886,646
10 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	655,295		655,295
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	655,295		655,295
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,541,941		4,541,941
17 00 ANCILLARY SERVICES	9,263,618	29,341,368	38,604,986
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY		437,262	437,262
24 00 PHYSICIAN CLINIC		2,690,128	2,690,128
25 00 TOTAL PATIENT REVENUES	13,805,559	32,468,758	46,274,317

PART II - OPERATING EXPENSES

26 00 OPERATING EXPENSES		24,793,371	
ADD (SPECIFY)			
27 00 PROVISION FOR BAD DEBTS	1,327,202		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		1,327,202	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		26,120,573	

STATEMENT OF REVENUES AND EXPENSES

DESCRIPTION		
1	TOTAL PATIENT REVENUES	46,274,317
2	LESS: ALLOWANCES AND DISCOUNTS ON	20,581,164
3	NET PATIENT REVENUES	25,693,153
4	LESS: TOTAL OPERATING EXPENSES	26,120,573
5	NET INCOME FROM SERVICE TO PATIENT	-427,420
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	69,233
7	INCOME FROM INVESTMENTS	378,927
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	2,526
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	48,708
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUTION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	32,334
24	DR. SCHULER	10,840
24.01	DIETICIAN REVENUE	4,350
24.02	CHAP PAYMENT	154,700
24.03	RENTAL REVENUE	52,164
24.04	AMB SUPPLIES	8,710
24.05	OTPT CLINIC	20,000
24.06	LAB QUAL CN	1,391
24.08	COMMUNITY HEALTH	30,241
24.09	CTC REVENUE	3,282
24.10	MEALS ON WHEELS	16,569
24.11	ILLINOIS HEALTH CENTER	10,213
24.12	MISCELLANEOUS	141,511
24.13		
25	TOTAL OTHER INCOME	985,699
26	TOTAL	558,279
	OTHER EXPENSES	
27	NON-OPERATING REVENUE	39
27.07	CHARITY CARE	601,146
28		
29		
30	TOTAL OTHER EXPENSES	601,185
31	NET INCOME (OR LOSS) FOR THE PERIO	-42,906

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5	109,671				30,768	140,439
HHA REIMBURSABLE SERVICES						
6	156,236		16,323			172,559
7	18,841					18,841
8	4,418					4,418
9	167					167
10	1,584					1,584
11	10,055					10,055
12						
13						
13.20					472	472
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24	300,972		16,323		31,240	348,535

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5		140,439	-4,448	135,991
HHA REIMBURSABLE SERVICES				
6		172,559		172,559
7		18,841		18,841
8		4,418		4,418
9		167		167
10		1,584		1,584
11		10,055		10,055
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24	-472	348,063	-4,448	343,615

HHA 1

	CAP-REL COST-BLDG & FIX (FEET SQUARE)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (FEET SQUARE)	TRANSPORTATION (MILEAGE)	RECONCILIATION ()	ADMINISTRATIVE & GENERAL (COST ACCUM)
	1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS						
1 CAP-REL COST-BLDG & FIX						
2 CAP-REL COST-MOV EQUIP						
3 PLANT OPER & MAINT						
4 TRANSPORTATION						
5 ADMINISTRATIVE & GENERAL					- 135,991	207,624
HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE						172,559
7 PHYSICAL THERAPY						18,841
8 OCCUPATIONAL THERAPY						4,418
9 SPEECH PATHOLOGY						167
10 MEDICAL SOCIAL SERVICES						1,584
11 HOME HEALTH AIDE						10,055
12 SUPPLIES						
13 DRUGS						
13.20 COST ADMINISTERING DRUGS						
14 DME						
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SVCS						
16 RESPIRATORY THERAPY						
17 PRIVATE DUTY NURSING						
18 CLINIC						
19 HEALTH PROM ACTIVITIES						
20 DAY CARE PROGRAM						
21 HOME DEL MEALS PROGRAM						
22 HOMEMAKER SERVICE						
23 ALL OTHERS						
23.50 TELEMEDICINE						
24 TOTAL (SUM OF LINES 1-23)					- 135,991	207,624
25 COST TO BE ALLOCATED						135,991
26 UNIT COST MULTIPLIER						.654987

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1)	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	BUSINESS OFF ICE 6.01
1 ADMIN & GENERAL		4,061	13,308	31,712	49,081	1,355
2 SKILLED NURSING CARE	285,583			45,177	330,760	9,130
3 PHYSICAL THERAPY	31,182			5,448	36,630	1,011
4 OCCUPATIONAL THERAPY	7,312			1,326	8,638	238
5 SPEECH PATHOLOGY	276				276	8
6 MEDICAL SOCIAL SERVICES	2,621			458	3,079	85
7 HOME HEALTH AIDE	16,641			2,907	19,548	540
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	343,615	4,061	13,308	87,028	448,012	12,367
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	SUBTOTAL 6A.01	DATA PROCESS ING 6.02	SUBTOTAL 6A.02	ADMITTING 6.03	SUBTOTAL 6A.03	OTHER ADMINI STRATIVE AND 6.04
1 ADMIN & GENERAL	50,436	1,559	51,995	526	52,521	5,048
2 SKILLED NURSING CARE	339,890	10,509	350,399	3,543	353,942	34,016
3 PHYSICAL THERAPY	37,641	1,164	38,805	392	39,197	3,767
4 OCCUPATIONAL THERAPY	8,876	274	9,150	92	9,242	888
5 SPEECH PATHOLOGY	284	9	293	3	296	28
6 MEDICAL SOCIAL SERVICES	3,164	98	3,262	33	3,295	317
7 HOME HEALTH AIDE	20,088	621	20,709	209	20,918	2,010
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	460,379	14,234	474,613	4,798	479,411	46,074
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	MEDICAL RECO RDS & LI BRAR 17
1 ADMIN & GENERAL	26,584		6,720			
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	26,584		6,720			
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	SOCIAL SERVICE	SUBTOTAL	POST DOWN	STEP ADJUST	SUBTOTAL	ALLOCATED HHA A & G	TOTAL HHA COSTS
	18	25		26	27	28	29
1 ADMIN & GENERAL		90,873			90,873		
2 SKILLED NURSING CARE		387,958			387,958	75,185	463,143
3 PHYSICAL THERAPY		42,964			42,964	8,326	51,290
4 OCCUPATIONAL THERAPY		10,130			10,130	1,963	12,093
5 SPEECH PATHOLOGY		324			324	63	387
6 MEDICAL SOCIAL SERVICES	995	4,607			4,607	893	5,500
7 HOME HEALTH AIDE		22,928			22,928	4,443	27,371
8 SUPPLIES							
9 DRUGS							
9.20 COST ADMINISTERING DRUGS							
10 DME							
11 HOME DIALYSIS AIDE SVCS							
12 RESPIRATORY THERAPY							
13 PRIVATE DUTY NURSING							
14 CLINIC							
15 HEALTH PROM ACTIVITIES							
16 DAY CARE PROGRAM							
17 HOME DEL MEALS PROGRAM							
18 HOMEMAKER SERVICE							
19 ALL OTHER							
19.50 TELEMEDICINE							
20 TOTAL (SUM OF 1-19) (2)	995	559,784			559,784	90,873	559,784
21 UNIT COST MULTIPLIER						0.193796	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
 (2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE (SQUARE FEET) 4	EMPLOYEE BEN EFITS (GROSS SALARIES) 5	RECONCILIATI ON 6A. 01	BUSINESS OFF ICE (ACCUM COST) 6. 01	RECONCILIATI ON 6A. 02
1 ADMIN & GENERAL	1,200	1,200	109,671		49,081	
2 SKILLED NURSING CARE			156,236		330,760	
3 PHYSICAL THERAPY			18,841		36,630	
4 OCCUPATIONAL THERAPY			4,585		8,638	
5 SPEECH PATHOLOGY					276	
6 MEDICAL SOCIAL SERVICES			1,584		3,079	
7 HOME HEALTH AIDE			10,055		19,548	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	1,200	1,200	300,972		448,012	
21 COST TO BE ALLOCATED	4,061	13,308	87,028		12,367	
22 UNIT COST MULTIPLIER	3.384167	11.090000	0.289156		0.027604	

HHA COST CENTER	DATA PROCESS ING (ACCUM COST) 6. 02	RECONCILIATI ON 6A. 03	ADMITTING (ACCUM. COST) 6. 03	RECONCILIATI ON 6A. 04	OTHER ADMINI STRATIVE AND (ACCUM COST) 6. 04	OPERATION OF PLANT (SQUARE FEET) 8
1 ADMIN & GENERAL	50,436		51,995		52,521	1,200
2 SKILLED NURSING CARE	339,890		350,399		353,942	
3 PHYSICAL THERAPY	37,641		38,805		39,197	
4 OCCUPATIONAL THERAPY	8,876		9,150		9,242	
5 SPEECH PATHOLOGY	284		293		296	
6 MEDICAL SOCIAL SERVICES	3,164		3,262		3,295	
7 HOME HEALTH AIDE	20,088		20,709		20,918	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	460,379		474,613		479,411	1,200
21 COST TO BE ALLOCATED	14,234		4,798		46,074	26,584
22 UNIT COST MULTIPLIER	0.030918		0.010109		0.096105	22.153333

HHA COST CENTER	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (HOURS OF SERVICE) 10	DIETARY (MEALS SERVED) 11	CAFETERIA (FTE'S) 12	MEDICAL RECO RDS & LIBRAR (TIME SPENT) 17	SOCIAL SERVI CE (TIME SPENT) 18
1 ADMIN & GENERAL		42				
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						4
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)		42				4
21 COST TO BE ALLOCATED		6,720				995
22 UNIT COST MULTIPLIER		160.000000				248.750000

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
PATIENT SERVICES							
1 SKILLED NURSING	2	463,143	2	463,143	1,874	247.14	1,015
2 PHYSICAL THERAPY	3	51,290		51,290	226	226.95	113
3 OCCUPATIONAL THERAPY	4	12,093		12,093	53	228.17	9
4 SPEECH PATHOLOGY	5	387		387	2	193.50	2
5 MEDICAL SOCIAL SERVICES	6	5,500		5,500	19	289.47	8
6 HOME HEALTH AIDE SERVICES	7	27,371		27,371	114	240.10	29
7 TOTAL		559,784		559,784	2,288		1,176

	PROGRAM VISITS		COST OF SERVICES		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	
1 SKILLED NURSING	7	266	9	10	12
2 PHYSICAL THERAPY		19	250,847	65,739	316,586
3 OCCUPATIONAL THERAPY		15	25,645	4,312	29,957
4 SPEECH PATHOLOGY			2,054	3,423	5,477
5 MEDICAL SOCIAL SERVICES		3	387		387
6 HOME HEALTH AIDE SERVICES		12	2,316	868	3,184
7 TOTAL		315	6,963	2,881	9,844
			288,212	77,223	365,435

LI MITATION COST COMPUTATION	PROGRAM COST LIMITS	PROGRAM VISITS PART A
PATIENT SERVICES		
8 SKILLED NURSING	1	6
9 PHYSICAL THERAPY	9914	
10 OCCUPATIONAL THERAPY	9914	
11 SPEECH PATHOLOGY	9914	
12 MEDICAL SOCIAL SERVICES	9914	
13 HOME HEALTH AIDE SERVICES	9914	
14 TOTAL		

	PROGRAM VISITS		COST OF SERVICES		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	
8 SKILLED NURSING	7	8	9	10	12
9 PHYSICAL THERAPY					
10 OCCUPATIONAL THERAPY					
11 SPEECH PATHOLOGY					
12 MEDICAL SOCIAL SERVICES					
13 HOME HEALTH AIDE SERVICES					
14 TOTAL					

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	PROGRAM COVERED CHARGES PART A
OTHER PATIENT SERVICES		1	2	3	4	5	6
15 COST OF MEDICAL SUPPLIES	8		3,989	3,989	15,782	.252756	
16 COST OF DRUGS	9		46	46	117	.393162	
16.20 COST OF DRUGS	9						

	PROGRAM COVERED CHARGES		COST OF SERVICES		
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	
	7	8	9	10	11
15 COST OF MEDICAL SUPPLIES					
16 COST OF DRUGS		28			11
16.20 COST OF DRUGS					

PER BENEFICIARY COST LIMITATION:	MSA NUMBER	AMOUNT
	1	2
162 PROGRAM UNDUP CENSUS FROM WRKST S-4	9914	
17 PER BENE COST LIMITATION (FRM FI)	9914	
18 PER BENE COST LIMITATION (LN 17*18)		

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

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO	TOTAL HHA CHARGES	HHA SHARED ANCILLARY COSTS	TRANSFER TO PART I AS INDICATED
	1	2	3	4	5
1 PHYSICAL THERAPY	50	.375047			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51	.780270			COL 2, LN 3
3 SPEECH PATHOLOGY	52	1.405065			COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.252730	15,782	3,989	COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.390560	117	46	COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5	COST PER VISIT	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE		PROG VISITS ON OR AFTER 1/1/1999
			PROGRAM VISITS PRIOR 1/1/1998	PROGRAM VISITS 1/1/1998 TO 12/31/1998	
	1	2	3	4	5
1 PHYSICAL THERAPY	2	226.95	2.01	3	
2 OCCUPATIONAL THERAPY	3	228.17		3.01	
3 SPEECH PATHOLOGY	4	193.50		4	
4 TOTAL (SUM OF LINES 1-3)					

TITLE XVIII HHA 1

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

	PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO DED & COINS
	1	2	3
1 REASONABLE COST OF SERVICES			11
2 TOTAL CHARGES			28
3 CUSTOMARY CHARGES			
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
5 AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
7 TOTAL CUSTOMARY CHARGES			28
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST			17
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
10 PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES	PART B SERVICES
	1	2
10 TOTAL REASONABLE COST		11
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	175,873	54,416
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	3,549	1,973
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES	2,026	
10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES	707	
10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11 TOTAL OTHER PAYMENTS		
10.12 DME PAYMENTS		
10.13 OXYGEN PAYMENTS		
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS		
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12 SUBTOTAL	182,155	56,400
13 EXCESS REASONABLE COST		
14 SUBTOTAL	182,155	56,400
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	182,155	56,400
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	182,155	56,400
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21 OTHER ADJUSTMENTS (SPECIFY)		
22 SUBTOTAL	182,155	56,400
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	182,155	56,400
25 INTERIM PAYMENTS	182,155	56,417
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE PROVIDER/PROGRAM		-17
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-11 SECTION 115.2		

TITLE XVIII HHA 1

DESCRIPTION	PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		182,155		56,417
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.		NONE		NONE
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. (1)				
ADJUSTMENTS TO PROVIDER	.01			
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50			
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
ADJUSTMENTS TO PROGRAM	.99			
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		182,155		56,417
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
TENTATIVE TO PROGRAM	.99			
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01		
	SETTLEMENT TO PROGRAM	.02		
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.