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

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

PART I - CERTIFICATION

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

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HOOPESTON COMMUNITY MEMORIAL HOSPITAL (14-1316) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2007 AND ENDING 09/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		199005	-140603	34861	1
2	SUBPROVIDER I					2
3	SWING BED - SNF		257830			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY		16716			5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	RURAL HEALTH CLINIC I			-2509		9
9.01	RURAL HEALTH CLINIC II			17		9.01
100	TOTAL		473551	-143095	34861	100

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1	STREET: 701 EAST ORANGE	P.O.BOX:			1
1.01	CITY: HOOPSETON STATE: IL	ZIP CODE: 60942	COUNTY: VERMILLION		1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX	
	0	1	2	3	4	5	6	
2	HOSPITAL	HOOPESTON COMMUNITY MEMORIAL HOSPI	14-1316	11/01/2001	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	HOOPESTON CMH SWING BED	14-Z316	11/01/2001	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF	HOOPESTON CMH SKILLED CARE	14-5470	11/01/2001	N	P	N	6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	HOOPESTON MEDICAL CENTER RHC	14-3448	04/01/1998	N	O	N	14
14.01	HOSP-BASED RHC II	CISSNA PARK	14-3485	10/11/2006	N	O	N	14.01
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2007	TO: 09/30/2008	17
		1	2	
18	TYPE OF CONTROL	2		18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL	1	19
20	SUBPROVIDER I		20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.			21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2		21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2		21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO		21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO		22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO		23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.			23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.			23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.			23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.			24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.			24.01

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

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO			25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	11/01/2001		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.	NO			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st	100	0.8320	0.8320	28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.	2	14	04	28.02

A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

28.03	STAFFING	0.00	N	28.03
28.04	RECRUITMENT	0.00	N	28.04
28.05	RETENTION OF EMPLOYEES	0.00	N	28.05
28.06	TRAINING	0.00	N	28.06
28.07	OTHER (SPECIFY)			28.07

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO		30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

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

MISCELLANEOUS COST REPORTING INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

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

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04

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

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

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

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

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

		DATE	Y/N	LIMIT	Y/N	FEES	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01

MULTICAMPUS

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

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

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	22	8030	29760.00		769		51		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					1131				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	22	8030	29760.00		1900		51		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY)									10
11	NURSERY									11
12	TOTAL HOSPITAL	22	8030	29760.00		1900		51		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY	75	27375			452				15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I				2627	5958				24
24.01	RHC II				62					24.01
25	TOTAL	97								25
26	OBSERVATION BED DAYS									26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA WORKSHEET S-3 PART I (CONTINUED)

	COMPONENT	I/P DAYS OBS. BEDS NOT ADMITTED 5.02	I/P DAYS TOTAL ALL PATIENTS 6	O/P VISITS / TRIPS OBS. BEDS ADMITTED 6.01	O/P VISITS / TRIPS OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES TOTAL 7	INTERNS & RES FTES LESS I&R REPL PHYS 8	INTERNS & RES FTES LESS I&R REPL NON-ANES 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	FULL TIME EQUIV NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1185								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		1131								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		980								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3296								5
6	INTENSIVE CARE UNIT										6
7	CORONARY CARE UNIT										7
8	BURN INTENSIVE CARE UNIT										8
9	SURGICAL INTENSIVE CARE UNIT										9
10	OTHER SPECIAL CARE (SPECIFY)										10
11	NURSERY										11
12	TOTAL HOSPITAL		3296						83.00		12
13	RPCH VISITS		18721								13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY		27113								15
16	NURSING FACILITY										16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY										18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I		12630						5.44		24
24.01	RHC II		578						.23		24.01
25	TOTAL								88.67		25
26	OBSERVATION BED DAYS		47		47						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	DISCHARGES TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		306	26	474	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		306	26	474	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
24.01	RHC II					24.01
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART II

	PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	6444097	-112178		369115.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF	1228475	-4353		90431.00			8
8.01	EXCLUDED AREA SALARIES	414920	-2832		28700.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	1128967					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	298941					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	75957			2597.00			21
22	ADMINISTRATIVE & GENERAL	640318			36428.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	161343			11669.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	247605			27268.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	331183			34056.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	93925			2160.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	190834			12561.00			33
34	SOCIAL SERVICE	48055			3301.00			34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART III

	PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
		1	2	3	4	5	
1	NET SALARIES	6444097	-112178	6331919	369115.00	17.15	1
2	EXCLUDED AREA SALARIES	1643395	-7185	1636210	119131.00	13.73	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	4800702	-104993	4695709	249984.00	18.78	3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS	1128967		1128967		24.04%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	5929669	-104993	5824676	249984.00	23.30	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	1789220		1789220	130040.00	13.76	13

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

	GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1st RATE	SERVICES PRIOR TO OCTOBER 1st DAYS	SERVICES ON OR AFTER OCTOBER 1st RATE	SERVICES ON OR AFTER OCTOBER 1st DAYS	SERVICES THROUGH 4/1/2001 - 9/30/2001 RATE	SERVICES THROUGH 4/1/2001 - 9/30/2001 DAYS	SWING BED SNF DAYS	TOTAL	
	1	2	3	3.01	4	4.01	4.02	4.03	4.06	5	
1		RUC									1
2		RUB									2
3		RUA									3
3.01		RUX									3.01
3.02		RUL									3.02
4		RVC		31							4
5		RVB									5
6		RVA									6
6.01		RVX		14							6.01
6.02		RVL		31							6.02
7		RHC									7
8		RHB		16							8
9		RHA		22							9
9.01		RHX									9.01
9.02		RHL									9.02
10		RMC		16							10
11		RMB									11
12		RMA									12
12.01		RMX		21							12.01
12.02		RML		14							12.02
13		RLB									13
14		RLA									14
14.01		RLX									14.01
15		SE3		90							15
16		SE2		70							16
17		SE1									17
18		SSC		40							18
19		SSB									19
20		SSA		43							20
21		CC2									21
22		CC1		30							22
23		CB2									23
24		CB1									24
25		CA2									25
26		CA1		14							26
27		IB2									27
28		IB1									28
29		IA2									29
30		IA1									30
31		BB2									31
32		BB1									32
33		BA2									33
34		BA1									34
35		PE2									35
36		PE1									36
37		PD2									37
38		PD1									38
39		PC2									39
40		PC1									40
41		PB2									41
42		PB1									42
43		PA2									43
44		PA1									44
45		DEFAULT RATE									45
46		TOTAL		452							46

RHC I WORKSHEET S-8

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

COMPONENT NO: 14-3448

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 801 EAST ORANGE STREET 1
1.01 CITY: HOOPESTON STATE: IL ZIP CODE: 60452 COUNTY: VERMILLION 1.01
2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

	SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6	APPALACHIAN REGIONAL COMMISSION		/ /	6
7	LOOK-ALIKES		/ /	7
8	OTHER		/ /	8

	PHYSICIAN INFORMATION:	PHYSICIAN NAME	BILLING NO.	
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. DANIEL BLIZZARD	E97041	9
9.01		DR. DAESUN OH	C37881	9.01
9.02		DR. TRAVIS CRAWFORD	H39752	9.02
9.03		KEITH WHITAKER PA	Q27231	9.03
9.04		MELIA SHIPMAN PA	Q55235	9.04
9.05		DR. DELGADO	C37049	9.05
9.06		DR. KUHA	F65791	9.06

		PHYSICIAN NAME	HOURS	
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
	0															
12	CLINIC			830	1830	830	1830	830	1700	830	1700	830	1700			12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13
14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14
IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.
15 PROVIDER NAME: PROVIDER NUMBER: - 15
V XVIII XIX
16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16
17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

RHC II WORKSHEET S-8

PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
PROVIDER STATISTICAL DATA

COMPONENT NO: 14-3485

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 141 W GARFIELD AVE.	1
1.01	CITY: CISSNA PARK STATE: IL ZIP CODE: 60924 COUNTY: IRIQUOIS	1.01
2	DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	2

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6 APPALACHIAN REGIONAL COMMISSION		/ /	6
7 LOOK-ALIKES		/ /	7
8 OTHER		/ /	8

PHYSICIAN INFORMATION:	PHYSICIAN NAME	BILLING NO.	
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. FRESCOLN	I57518	9
9.01	DR BLIZZARD	E97041	9.01
9.02	MELIA SHIPMAN PA	Q55235	9.02
9.03	KEITH WHITAKER PA	Q27231	9.03

	PHYSICIAN NAME	HOURS	
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
12	CLINIC			830	1300	830	1300	830	1300	830	1300	830	1300			12

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS OF OPERATION)
LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

13	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	NO	13
14	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.	NO	14
15	PROVIDER NAME:	PROVIDER NUMBER: - V XVIII XIX	15
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS.	NO	16
17	HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS.	NO	17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES	OTHER	TOTAL	RECLASSI-FICATIONS	RECLASS. TRIAL BALANCE	ADJUST-MENTS	NET EXP FOR ALLOCATION	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT		395338	395338	449193	844531	7959	852490	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		417266	417266	190896	608162		608162	4
5	0500	EMPLOYEE BENEFITS	75957	27819	103776	726284	830060	-4085	825975	5
6	0600	ADMINISTRATIVE & GENERAL	640318	3054952	3695270	-1242219	2453051	-106099	2346952	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	161343	402929	564272	30760	595032		595032	8
9	0900	LAUNDRY & LINEN SERVICE		123657	123657		123657		123657	9
10	1000	HOUSEKEEPING	247605	62767	310372		310372		310372	10
11	1100	DIETARY	331183	342508	673691		673691	-55070	618621	11
12	1200	CAFETERIA								12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	93925	8179	102104		102104		102104	14
15	1500	CENTRAL SERVICES & SUPPLY								15
16	1600	PHARMACY								16
17	1700	MEDICAL RECORDS & LIBRARY	190834	35033	225867		225867	-2837	223030	17
18	1800	SOCIAL SERVICE	48055	4655	52710		52710		52710	18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	713991	500165	1214156	4992	1219148	-272062	947086	25
34	3400	SKILLED NURSING FACILITY	1228475	157914	1386389	-24080	1362309		1362309	34
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	139928	584670	724598	-22091	702507		702507	37
40	4000	ANESTHESIOLOGY	112178	21624	133802		133802	-119990	13812	40
41	4100	RADIOLOGY-DIAGNOSTIC	291542	457543	749085	-31059	718026		718026	41
44	4400	LABORATORY	306086	335828	641914	-10778	631136	-12000	619136	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900	RESPIRATORY THERAPY	42200	55772	97972		97972	-14733	83239	49
50	5000	PHYSICAL THERAPY	15651	351384	367035		367035		367035	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
55	5500	MEDICAL SUPPLIES CHARGED TO PAT		144205	144205	-12445	131760		131760	55
56	5600	DRUGS CHARGED TO PATIENTS	58710	411277	469987		469987		469987	56
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	596051	865355	1461406	-18957	1442449	-171961	1270488	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC	735018	109931	844949	-6407	838542		838542	63.50
63.51	6311	RHC II	127	38040	38167	-3933	34234		34234	63.51
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
65	6500	AMBULANCE SERVICES	285514	110235	395749	-30156	365593		365593	65
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
95		SUBTOTALS	6314691	9019046	15333737		15333737	-750878	14582859	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800	PHYSICIANS' PRIVATE OFFICES								98
99.01	9901	ASSISTED LIVING	129406	26265	155671		155671		155671	99.01
100	7950	FOUNDATION		522	522		522		522	100
101		TOTAL	6444097	9045833	15489930		15489930	-750878	14739052	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		449193	1
2							2
3							3
4	RENT EXPENSE	B	NEW CAP REL COSTS-MVBLE EQUIP	4		190896	4
5		B					5
6		B					6
7		B					7
8		B					8
9		B					9
10		B					10
11		B					11
12							12
13	PHONE EXPENSE	C	ADMINISTRATIVE & GENERAL	6		1543	13
14							14
15	EMPLOYEE BENEFITS	D	EMPLOYEE BENEFITS	5		726284	15
16							16
17	UTILITY EXPENSE	E	OPERATION OF PLANT	8		41109	17
18		E					18
19		E					19
20		E					20
21		E					21
22							22
23	ACTIVITIES THERAPY	F	ADULTS & PEDIATRICS	25	4353	639	23
24							24
25	INSURANCE EXPENSE	G	ADMINISTRATIVE & GENERAL	6		49113	25
26		G					26
27							27
28	CRNA SALARIES	H	ANESTHESIOLOGY	40		112178	28
29							29
30	AMBULANCE NON PRODUCTIVE	I	EMERGENCY	61	2832		30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				7185	1570955	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	6		449193	11	1
2								2
3								3
4	RENT EXPENSE	B	ADMINISTRATIVE & GENERAL	6		108683	11	4
5		B	OPERATION OF PLANT	8		10349		5
6		B	OPERATING ROOM	37		22091		6
7		B	RADIOLOGY-DIAGNOSTIC	41		26550		7
8		B	LABORATORY	44		10778		8
9		B	MEDICAL SUPPLIES CHARGED TO P	55		12445		9
10		B						10
11		B						11
12								12
13	PHONE EXPENSE	C	RHC II	63.51		1543		13
14								14
15	EMPLOYEE BENEFITS	D	ADMINISTRATIVE & GENERAL	6		726284		15
16								16
17	UTILITY EXPENSE	E	ADMINISTRATIVE & GENERAL	6		8715		17
18		E	SKILLED NURSING FACILITY	34		19088		18
19		E	RADIOLOGY-DIAGNOSTIC	41		4509		19
20		E	RHC	63.50		6407		20
21		E	RHC II	63.51		2390		21
22								22
23	ACTIVITIES THERAPY	F	SKILLED NURSING FACILITY	34	4353	639		23
24								24
25	INSURANCE EXPENSE	G	EMERGENCY	61		21789		25
26		G	AMBULANCE SERVICES	65		27324		26
27								27
28	CRNA SALARIES	H	ANESTHESIOLOGY	40	112178			28
29								29
30	AMBULANCE NON PRODUCTIVE	I	AMBULANCE SERVICES	65	2832			30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				119363	1458777		36

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

WORKSHEET A-7
PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASE 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
1	LAND	164876					164876		1
2	LAND IMPROVEMENTS	228104				20003	208101		2
3	BUILDINGS AND FIXTURES	8094471	1080611		1080611		9175082		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	68139	205876		205876		274015		5
6	MOVABLE EQUIPMENT	3203143	26688		26688		3229831		6
7	SUBTOTAL	11758733	1313175		1313175	20003	13051905		7
8	RECONCILING ITEMS								8
9	TOTAL	11758733	1313175		1313175	20003	13051905		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	403297		449193				852490	3
4	NEW CAP REL COSTS-MVBLE EQUIP	417266		190896				608162	4
5	TOTAL	820563		640089				1460652	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	395338						395338	3
4	NEW CAP REL COSTS-MVBLE EQUIP	417266						417266	4
5	TOTAL	812604						812604	5

ADJUSTMENTS TO EXPENSES — WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED — COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-1	NEW CAP REL COSTS-BLDG & FIXT	3	9	8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-470756				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1					14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-43308	DIETARY	11		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-2837	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	B	-477	DIETARY	11		22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51		35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52		36
37	CATERING	B	-11285	DIETARY	11		37
38	PHYSICIAN OFFICE RENT	B	-200	NEW CAP REL COSTS-BLDG & FIXT	3	9	38
39	LOBBYING EXPENSE	A	-3437	ADMINISTRATIVE & GENERAL	6		39
40						9	40
41	MARKETING SALARIES	A	-2836	ADMINISTRATIVE & GENERAL	6		41
42	MARKETING EXPENSE	A	-69795	ADMINISTRATIVE & GENERAL	6		42
43	MARKETING BENEFITS	A	-283	ADMINISTRATIVE & GENERAL	6		43
44	MISCELLANEOUS REVENUE	B	-29747	ADMINISTRATIVE & GENERAL	6		44
45							45
46							46
47	CRNA SALARIES	A	-112178	ANESTHESIOLOGY	40		47
47.01	CRNA BENEFITS	A	-4085	EMPLOYEE BENEFITS	5		47.01
47.02	CRNA OTHER	A	-7812	ANESTHESIOLOGY	40		47.02
48							48
49	IDPA ASSESSMENT	A	-1	ADMINISTRATIVE & GENERAL	6		49
49.02	POB LAPSING SCHEDULE	A	8160	NEW CAP REL COSTS-BLDG & FIXT	3	9	49.02
50	TOTAL		-750878				50

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

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

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

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

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

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

		-------- RELATED ORGANIZATION(S) AND/OR HOME OFFICE ----------				
SYMBOL (1)	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	PERCENT OF UNADJUSTED RCE LIMIT
	1	2		3	4	5	6	7	8	9
1	25	ADULTS & PEDIATRICS	AGGREGATE	415228	272062	143166				
2	44	LABORATORY	AGGREGATE	12000	12000					
3	49	RESPIRATORY THERAPY	AGGREGATE	14733	14733					
4	61	EMERGENCY	AGGREGATE	730051	171961	558090				
101		TOTAL		1172012	470756	701256				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT
	10	11		12	13	14	15	16	17	18
1	25	ADULTS & PEDIATRICS	AGGREGATE							272062
2	44	LABORATORY	AGGREGATE							12000
3	49	RESPIRATORY THERAPY	AGGREGATE							14733
4	61	EMERGENCY	AGGREGATE							171961
101		TOTAL								470756

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	320	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	45	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		226.00	1359.00			9
10	AHSEA		63.73	46.90			10
11	STANDARD TRAVEL ALLOWANCE	31.87	31.87	23.45			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	14403	15
16	ASSISTANTS	63737	16
17	SUBTOTAL ALLOWANCE AMOUNT	78140	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	78140	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	78140	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	10198	24
25	ASSISTANTS	1055	25
26	SUBTOTAL	11253	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	11253	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	11253	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	78140	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	11253	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	89393	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	51175	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS V,VI & VII

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	51175	66
67	TOTAL COST	51175	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	140	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	225	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		3043.00	31.00			9
10	AHSEA		64.56	48.48			10
11	STANDARD TRAVEL ALLOWANCE	32.28	32.28	24.24			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS		14
15	THERAPISTS	196456	15
16	ASSISTANTS	1503	16
17	SUBTOTAL ALLOWANCE AMOUNT	197959	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	197959	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	197959	23

REASONABLE COST DETERMINATION FOR THERAPY SERVICES — WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 — PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4519	24
25	ASSISTANTS	5454	25
26	SUBTOTAL	9973	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	9973	28
	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	9973	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	197959	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	9973	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	207932	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	158193	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES | WORKSHEET A-8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998 | PARTS V,VI & VII

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	158193	66
67	TOTAL COST	158193	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	852490	852490							3
4	NEW CAP REL COSTS-MVBLE EQUIP	608162		608162						4
5	EMPLOYEE BENEFITS	825975			825975					5
6	ADMINISTRATIVE & GENERAL	2346952	266480	190105	84541	2888078	2888078			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	595032	28250	20153	21302	664737	161996	826733		8
9	LAUNDRY & LINEN SERVICE	123657	8038	5735		137430	33492	11915	182837	9
10	HOUSEKEEPING	310372	6419	4579	32691	354061	86285	9515		10
11	DIETARY	618621	25079	17891	43726	705317	171886	37173		11
12	CAFETERIA		4077	2909		6986	1702	6043		12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	102104	6641	4738	12401	125884	30678	9843		14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	223030	8135	5803	25196	262164	63889	12058		17
18	SOCIAL SERVICE	52710	2901	2070	6345	64026	15603	4300		18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	947086	29060	20731	94843	1091720	266052	43073	54341	25
34	SKILLED NURSING FACILITY	1362309	107940	77004	161621	1708874	416449	159992	89609	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	702507	15084	10761	18475	746827	182002	22358		37
40	ANESTHESIOLOGY	13812				13812	3366			40
41	RADIOLOGY-DIAGNOSTIC	718026	34409	24547	38492	815474	198731	51002		41
44	LABORATORY	619136	12751	9097	40413	681397	166056	18901		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	83239	4723	3369	5572	96903	23615	7000		49
50	PHYSICAL THERAPY	367035	6448	4600	2066	380149	92642	9558		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT	131760	6978	4978		143716	35024	10343		55
56	DRUGS CHARGED TO PATIENTS	469987	2419	1726	7751	481883	117435	3586		56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1270488	15778	11256	79071	1376593	335476	23387		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	838542	93492	66696	97044	1095774	267040	138577		63.50
63.51	RHC II	34234			17	34251	8347			63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	365593			37323	402916	98191			65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	14582859	685102	488748	808890	14278972	2775957	578624	143950	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		9002	6422		15424	3759	13343		96
98	PHYSICIANS' PRIVATE OFFICES									98
99.01	ASSISTED LIVING	155671	158386	112992	17085	444134	108235	234766	38887	99.01
100	FOUNDATION	522				522	127			100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	14739052	852490	608162	825975	14739052	2888078	826733	182837	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		10	11	12	14	17	18	25	26	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	449861								10
11	DIETARY	20766	935142							11
12	CAFETERIA	3376	120947	139054						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	5499		1271	173175					14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	6736		7389		352236				17
18	SOCIAL SERVICE	2402		1942			88273			18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	24062	64816	18579	70952	69351	8818	1711764		25
34	SKILLED NURSING FACILITY	89375	533586	53194	38350	20483	75031	3184943		34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	12490		2417	14188	23063		1003345		37
40	ANESTHESIOLOGY			1224				18402		40
41	RADIOLOGY-DIAGNOSTIC	28491		7068		54835		1155601		41
44	LABORATORY	10558		8528		38707		924147		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	3911		1216		32256		164901		49
50	PHYSICAL THERAPY	5339		911		16934		505533		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT	5778						194861		55
56	DRUGS CHARGED TO PATIENTS	2003						604907		56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	13064		14933	49685	67415	4424	1884977		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	77412		14097		25160		1618060		63.50
63.51	RHC II							42598		63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES					806		501913		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	311262	719349	132769	173175	349010	88273	13515952		95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN	7454						39980		96
98	PHYSICIANS' PRIVATE OFFICES					3226		3226		98
99.01	ASSISTED LIVING	131145	215793	6285				1179245		99.01
100	FOUNDATION							649		100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	449861	935142	139054	173175	352236	88273	14739052		103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	TOTAL	
		27	
	GENERAL SERVICE COST CENTERS		
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY		17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES A		22
23	I&R SERVICES-OTHER PRGM COSTS A		23
24	PARAMED ED PRGM-(SPECIFY)		24
	INPATIENT ROUTINE SERV COST CENTERS		
25	ADULTS & PEDIATRICS	1711764	25
34	SKILLED NURSING FACILITY	3184943	34
	ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	1003345	37
40	ANESTHESIOLOGY	18402	40
41	RADIOLOGY-DIAGNOSTIC	1155601	41
44	LABORATORY	924147	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO		46.30
49	RESPIRATORY THERAPY	164901	49
50	PHYSICAL THERAPY	505533	50
51	OCCUPATIONAL THERAPY		51
52	SPEECH PATHOLOGY		52
55	MEDICAL SUPPLIES CHARGED TO PAT	194861	55
56	DRUGS CHARGED TO PATIENTS	604907	56
	OUTPATIENT SERVICE COST CENTERS		
61	EMERGENCY	1884977	61
62	OBSERVATION BEDS (NON-DISTINCT		62
63.50	RHC	1618060	63.50
63.51	RHC II	42598	63.51
63.60	FQHC		63.60
	OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES	501913	65
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
	SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	13515952	95
	NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & CAN	39980	96
98	PHYSICIANS' PRIVATE OFFICES	3226	98
99.01	ASSISTED LIVING	1179245	99.01
100	FOUNDATION	649	100
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	TOTAL	14739052	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL		266480	190105	456585	456585				6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		28250	20153	48403	25610	74013			8
9	LAUNDRY & LINEN SERVICE		8038	5735	13773	5295	1067	20135		9
10	HOUSEKEEPING		6419	4579	10998	13641	852		25491	10
11	DIETARY		25079	17891	42970	27174	3328		1177	11
12	CAFETERIA		4077	2909	6986	269	541		191	12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		6641	4738	11379	4850	881		312	14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		8135	5803	13938	10100	1079		382	17
18	SOCIAL SERVICE		2901	2070	4971	2467	385		136	18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		29060	20731	49791	42061	3856	5984	1363	25
34	SKILLED NURSING FACILITY		107940	77004	184944	65840	14323	9869	5064	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		15084	10761	25845	28773	2002		708	37
40	ANESTHESIOLOGY					532				40
41	RADIOLOGY-DIAGNOSTIC		34409	24547	58956	31418	4566		1614	41
44	LABORATORY		12751	9097	21848	26252	1692		598	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY		4723	3369	8092	3733	627		222	49
50	PHYSICAL THERAPY		6448	4600	11048	14646	856		303	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT		6978	4978	11956	5537	926		327	55
56	DRUGS CHARGED TO PATIENTS		2419	1726	4145	18566	321		114	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		15778	11256	27034	53036	2094		740	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC		93492	66696	160188	42217	12406		4387	63.50
63.51	RHC II					1320				63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES					15523				65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS		685102	488748	1173850	438860	51802	15853	17638	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		9002	6422	15424	594	1195		422	96
98	PHYSICIANS' PRIVATE OFFICES									98
99.01	ASSISTED LIVING		158386	112992	271378	17111	21016	4282	7431	99.01
100	FOUNDATION					20				100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		852490	608162	1460652	456585	74013	20135	25491	103

ALLOCATION OF NEW CAPITAL RELATED COSTS — WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		11	12	14	17	18	25	26	27	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING									10
11	DIETARY	74649								11
12	CAFETERIA	9655	17642							12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		161	17583						14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		937		26436					17
18	SOCIAL SERVICE		246			8205				18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	5174	2357	7203	5205	820	123814		123814	25
34	SKILLED NURSING FACILITY	42594	6750	3894	1537	6974	341789		341789	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		307	1441	1731		60807		60807	37
40	ANESTHESIOLOGY		155				687		687	40
41	RADIOLOGY-DIAGNOSTIC		897		4115		101566		101566	41
44	LABORATORY		1082		2905		54377		54377	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY		154		2421		15249		15249	49
50	PHYSICAL THERAPY		116		1271		28240		28240	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT						18746		18746	55
56	DRUGS CHARGED TO PATIENTS						23146		23146	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		1895	5045	5060	411	95315		95315	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC		1788		1888		222874		222874	63.50
63.51	RHC II						1320		1320	63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES				61		15584		15584	65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	57423	16845	17583	26194	8205	1103514		1103514	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN						17635		17635	96
98	PHYSICIANS' PRIVATE OFFICES				242		242		242	98
99.01	ASSISTED LIVING	17226	797				339241		339241	99.01
100	FOUNDATION						20		20	100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	74649	17642	17583	26436	8205	1460652		1460652	103

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	88448							3
4	NEW CAP REL COSTS-MVBLE EQUIP		88448						4
5	EMPLOYEE BENEFITS			6255962					5
6	ADMINISTRATIVE & GENERAL	27648	27648	640318	-2888078	11850974			6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT	2931	2931	161343		664737	57869		8
9	LAUNDRY & LINEN SERVICE	834	834			137430	834	222297	9
10	HOUSEKEEPING	666	666	247605		354061	666		10
11	DIETARY	2602	2602	331183		705317	2602		11
12	CAFETERIA	423	423			6986	423		12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION	689	689	93925		125884	689		14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY	844	844	190834		262164	844		17
18	SOCIAL SERVICE	301	301	48055		64026	301		18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	3015	3015	718344		1091720	3015	66069	25
34	SKILLED NURSING FACILITY	11199	11199	1224122		1708874	11199	108949	34
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	1565	1565	139928		746827	1565		37
40	ANESTHESIOLOGY					13812			40
41	RADIOLOGY-DIAGNOSTIC	3570	3570	291542		815474	3570		41
44	LABORATORY	1323	1323	306086		681397	1323		44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY	490	490	42200		96903	490		49
50	PHYSICAL THERAPY	669	669	15651		380149	669		50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P	724	724			143716	724		55
56	DRUGS CHARGED TO PATIENTS	251	251	58710		481883	251		56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	1637	1637	598883		1376593	1637		61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC	9700	9700	735018		1095774	9700		63.50
63.51	RHC II			127		34251			63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES			282682		402916			65
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	71081	71081	6126556	-2888078	11390894	40502	175018	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	934	934			15424	934		96
98	PHYSICIANS' PRIVATE OFFICES								98
99.01	ASSISTED LIVING	16433	16433	129406		444134	16433	47279	99.01
100	FOUNDATION					522			100

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	852490	608162	825975		2888078	826733	182837	103
104	UNIT COST MULT-WS B PT I		6.875927				14.286285		104
104	UNIT COST MULT-WS B PT I	9.638319		.132030		.243700		.822490	104
105	COST TO BE ALLOC PER B PT II								105
106	UNIT COST MULT-WS B PT II								106
106	UNIT COST MULT-WS B PT II								106
107	COST TO BE ALLOC PER B PT III					456585	74013	20135	107
108	UNIT COST MULT-WS B PT III						1.278975		108
108	UNIT COST MULT-WS B PT III					.038527		.090577	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	56369								10
11	DIETARY	2602	133498							11
12	CAFETERIA	423	17266	236387						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	689		2160	46186					14
15	CENTRAL SERVICES & SUPPLY					100				15
16	PHARMACY						100			16
17	MEDICAL RECORDS & LIBRARY	844		12561				10920		17
18	SOCIAL SERVICE	301		3301					2893	18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES									22
23	I&R SERVICES-OTHER PRGM COSTS									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	3015	9253	31584	18923			2150	289	25
34	SKILLED NURSING FACILITY	11199	76173	90431	10228			635	2459	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	1565		4109	3784			715		37
40	ANESTHESIOLOGY			2080						40
41	RADIOLOGY-DIAGNOSTIC	3570		12015				1700		41
44	LABORATORY	1323		14498				1200		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY	490		2067				1000		49
50	PHYSICAL THERAPY	669		1548				525		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO P	724				100				55
56	DRUGS CHARGED TO PATIENTS	251					100			56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1637		25385	13251			2090	145	61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RHC	9700		23964				780		63.50
63.51	RHC II									63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES							25		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERA									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	39002	102692	225703	46186	100	100	10820	2893	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & C	934								96
98	PHYSICIANS' PRIVATE OFFICES							100		98
99.01	ASSISTED LIVING	16433	30806	10684						99.01
100	FOUNDATION									100

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	449861	935142	139054	173175			352236	88273	103
104	UNIT COST MULT-WS B PT I	7.980645		.588247				32.256044		104
104	UNIT COST MULT-WS B PT I		7.004914		3.749513				30.512617	104
105	COST TO BE ALLOC PER B PT II									105
106	UNIT COST MULT-WS B PT II									106
106	UNIT COST MULT-WS B PT II									106
107	COST TO BE ALLOC PER B PT III	25491	74649	17642	17583			26436	8205	107
108	UNIT COST MULT-WS B PT III	.452217		.074632				2.420879		108
108	UNIT COST MULT-WS B PT III		.559177		.380700				2.836156	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	GENERAL SERVICE COST CENTERS	
1	OLD CAP REL COSTS-BLDG & FIXT	1
2	OLD CAP REL COSTS-MVBLE EQUIP	2
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
7	MAINTENANCE & REPAIRS	7
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
13	MAINTENANCE OF PERSONNEL	13
14	NURSING ADMINISTRATION	14
15	CENTRAL SERVICES & SUPPLY	15
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
20	NONPHYSICIAN ANESTHETISTS	20
21	NURSING SCHOOL	21
22	I&R SERVICES-SALARY & FRINGES	22
23	I&R SERVICES-OTHER PRGM COSTS	23
24	PARAMED ED PRGM-(SPECIFY)	24
	INPATIENT ROUTINE SERV COST CENTERS	
25	ADULTS & PEDIATRICS	25
34	SKILLED NURSING FACILITY	34
	ANCILLARY SERVICE COST CENTERS	
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
46.30	BLOOD CLOTTING FACTORS ADMIN	46.30
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
	OUTPATIENT SERVICE COST CENTERS	
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RHC	63.50
63.51	RHC II	63.51
63.60	FQHC	63.60
	OTHER REIMBURSABLE COST CENTERS	
65	AMBULANCE SERVICES	65
69.10	CMHC	69.10
69.20	OUTPATIENT PHYSICAL THERAPY	69.20
69.30	OUTPATIENT OCCUPATIONAL THERA	69.30
69.40	OUTPATIENT SPEECH PATHOLOGY	69.40
71	HOME HEALTH AGENCY	71
	SPECIAL PURPOSE COST CENTERS	
85.01	PANCREAS ACQUISITION	85.01
85.02	INTESTINAL ACQUISITION	85.02
85.03	ISLET CELL ACQUISITION	85.03
95	SUBTOTALS	95
	NONREIMBURSABLE COST CENTERS	
96	GIFT, FLOWER, COFFEE SHOP & C	96
98	PHYSICIANS' PRIVATE OFFICES	98
99.01	ASSISTED LIVING	99.01
100	FOUNDATION	100

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
101	CROSS FOOT ADJUSTMENTS	101
102	NEGATIVE COST CENTER	102
103	COST TO BE ALLOC PER B PT I	103
104	UNIT COST MULT-WS B PT I	104
104	UNIT COST MULT-WS B PT I	104
105	COST TO BE ALLOC PER B PT II	105
106	UNIT COST MULT-WS B PT II	106
106	UNIT COST MULT-WS B PT II	106
107	COST TO BE ALLOC PER B PT III	107
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	108

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	1711764		1711764		1711764	25
34	SKILLED NURSING FACILITY	3184943		3184943		3184943	34
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1003345		1003345		1003345	37
40	ANESTHESIOLOGY	18402		18402		18402	40
41	RADIOLOGY-DIAGNOSTIC	1155601		1155601		1155601	41
44	LABORATORY	924147		924147		924147	44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	164901		164901		164901	49
50	PHYSICAL THERAPY	505533		505533		505533	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO	194861		194861		194861	55
56	DRUGS CHARGED TO PATIENTS	604907		604907		604907	56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1884977		1884977		1884977	61
62	OBSERVATION BEDS (NON-DISTI	32127		32127		32127	62
63.50	RHC	1618060		1618060		1618060	63.50
63.51	RHC II	42598		42598		42598	63.51
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES	501913		501913		501913	65
101	SUBTOTAL	13548079		13548079		13548079	101
102	LESS OBSERVATION BEDS	32127		32127		32127	102
103	TOTAL	13515952		13515952		13515952	103

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

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	851005		851005				25
34	SKILLED NURSING FACILITY	3678590		3678590				34
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	100221	3250042	3350263	.299482	.299482	.299482	37
40	ANESTHESIOLOGY	1132		1132	16.256184	16.256184	16.256184	40
41	RADIOLOGY-DIAGNOSTIC	257079	3784971	4042050	.285895	.285895	.285895	41
44	LABORATORY	610433	2589889	3200322	.288767	.288767	.288767	44
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
49	RESPIRATORY THERAPY	422290	1144943	1567233	.105218	.105218	.105218	49
50	PHYSICAL THERAPY	626314	714908	1341222	.376920	.376920	.376920	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO	1218430	1732236	2950666	.066040	.066040	.066040	55
56	DRUGS CHARGED TO PATIENTS	1422074	1025590	2447664	.247136	.247136	.247136	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	179730	4139325	4319055	.436433	.436433	.436433	61
62	OBSERVATION BEDS (NON-DISTI		104573	104573	.307221	.307221	.307221	62
63.50	RHC							63.50
63.51	RHC II							63.51
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES		962973	962973	.521212	.521212	.521212	65
101	SUBTOTAL	9367298	19449450	28816748				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	9367298	19449450	28816748				103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST — WORKSHEET D, PARTS V & VI

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1316)	[ ] SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ] NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ] S/B-SNF
			[ ]	SUB III	[ ] S/B-NF
			[ ]	SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES — OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.299482	.299482	.299482				37
40	ANESTHESIOLOGY	16.256184	16.256184	16.256184				40
41	RADIOLOGY-DIAGNOSTIC	.285895	.285895	.285895				41
44	LABORATORY	.288767	.288767	.288767				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.105218	.105218	.105218				49
50	PHYSICAL THERAPY	.376920	.376920	.376920				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO PAT	.066040	.066040	.066040				55
56	DRUGS CHARGED TO PATIENTS	.247136	.247136	.247136				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.436433	.436433	.436433				61
62	OBSERVATION BEDS (NON-DISTINCT	.307221	.307221	.307221				62
63.50	RHC							63.50
63.51	RHC II							63.51
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	.521212	.521212	.521212				65
65.01	AMBULANCE CHARGES (S-2 LINE 56.	.521212	.521212					65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.	.521212	.521212					65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.	.521212	.521212					65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	.247136	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST WORKSHEET D
PARTS V & VI

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1316)	[ ]	SNF	
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF	
BOXES	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF	
			[ ]	SUB III	[ ]	S/B-NF	
			[ ]	SUB IV	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST OUTPATIENT RADIOLOGY 7	PROGRAM COST OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	1285948								37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	1229157								41
44	LABORATORY	881188								44
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY	508643								49
50	PHYSICAL THERAPY	230448								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PA	312072								55
56	DRUGS CHARGED TO PATIENTS	649842								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1063500								61
62	OBSERVATION BEDS (NON-DISTINCT	29654								62
63.50	RHC									63.50
63.51	RHC II									63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
65.01	AMBULANCE CHARGES (S-2 LINE 56									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	6190452								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	6190452								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST — WORKSHEET D, PARTS V & VI

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1316)	[ ] SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ] NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ] S/B-SNF
			[ ]	SUB III	[ ] S/B-NF
			[ ]	SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5)	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01)	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02)	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03	PPS SERVICES (COLUMNS 1.01x5.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.)	HOSPITAL I/P PART B COST (COLUMNS 1.02x10)	
		9	9.01	9.02	9.03	9.04	10	11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	385118							37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	351410							41
44	LABORATORY	254458							44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY	53518							49
50	PHYSICAL THERAPY	86860							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO PAT	20609							55
56	DRUGS CHARGED TO PATIENTS	160599							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	464146							61
62	OBSERVATION BEDS (NON-DISTINCT	9110							62
63.50	RHC								63.50
63.51	RHC II								63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
65.01	AMBULANCE CHARGES (S-2 LINE 56.								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	1785828							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1785828							104

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV		[ ]	PPS		
	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF	(14-5470)	[ ]	TEFRA		
	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF					
			[ ]	SUB III	[ ]	ICF/MR					

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		1	1.01	2	2.01	2.02	2.03	3	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM								37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY								49
50	PHYSICAL THERAPY								50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P								55
56	DRUGS CHARGED TO PATIENTS								56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY								61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC								63.50
63.51	RHC II								63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL								101

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV		[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF	(14-5470)	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF			
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		3350263						37
40	ANESTHESIOLOGY		1132						40
41	RADIOLOGY-DIAGNOSTIC		4042050			3329			41
44	LABORATORY		3200322			4177			44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		1567233			15682			49
50	PHYSICAL THERAPY		1341222			33724			50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P		2950666			14753			55
56	DRUGS CHARGED TO PATIENTS		2447664			83999			56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		4319055						61
62	OBSERVATION BEDS (NON-DISTINC		104573						62
63.50	RHC								63.50
63.51	RHC II								63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL		23324180			155664			101

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV		[ ]	PPS
	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF	(14-5470)	[ ]	TEFRA
	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF			
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO P						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
101	TOTAL						101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL: CAPITAL RELATED COST (1)	OLD CAPITAL: SWING-BED ADJUSTMENT (2)	OLD CAPITAL: REDUCED CAPITAL RELATED COST (3)	NEW CAPITAL: CAPITAL RELATED COST (4)	NEW CAPITAL: SWING-BED ADJUSTMENT (5)	NEW CAPITAL: REDUCED CAPITAL RELATED COST (6)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				123814	62901	60913	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL				123814		60913	101

	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS (7)	INPATIENT PROGRAM DAYS (8)	OLD CAPITAL: PER DIEM (9)	OLD CAPITAL: INPATIENT PROGRAM CAPITAL COST (10)	NEW CAPITAL: PER DIEM (11)	NEW CAPITAL: INPATIENT PROGRAM CAPITAL COST (12)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS	1232	51			49.44	2521	25
26	INTENSIVE CARE UNIT							26
27	CORONARY CARE UNIT							27
28	BURN INTENSIVE CARE UNIT							28
29	SURGICAL INTENSIVE CARE UNIT							29
30	OTHER SPECIAL CARE (SPECIFY)							30
31	SUBPROVIDER I							31
33	NURSERY							33
101	TOTAL	1232	51				2521	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX] HOSPITAL (14-1316)	[ ] SUB III	[ ] PPS
	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SUB IV	[ ] TEFRA
	[XX] TITLE XIX	[ ] SUB II	[XX] OTHER	

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		60807	3350263				.018150		37
40	ANESTHESIOLOGY		687	1132				.606890		40
41	RADIOLOGY-DIAGNOSTIC		101566	4042050				.025127		41
44	LABORATORY		54377	3200322				.016991		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY		15249	1567233				.009730		49
50	PHYSICAL THERAPY		28240	1341222				.021055		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO P		18746	2950666				.006353		55
56	DRUGS CHARGED TO PATIENTS		23146	2447664				.009456		56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		95315	4319055				.022068		61
62	OBSERVATION BEDS (NON-DISTINC			104573						62
63.50	RHC									63.50
63.51	RHC II									63.51
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
101	TOTAL		398133	23324180						101

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

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					1232		51		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY					27113				34
35	NURSING FACILITY									35
101	TOTAL					28345		51		101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ] OTHER
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		1	1.01	2	2.01	2.02	2.03	3	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM								37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY								49
50	PHYSICAL THERAPY								50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P								55
56	DRUGS CHARGED TO PATIENTS								56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY								61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC								63.50
63.51	RHC II								63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL								101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER	
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		3350263						37
40	ANESTHESIOLOGY		1132						40
41	RADIOLOGY-DIAGNOSTIC		4042050						41
44	LABORATORY		3200322						44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		1567233						49
50	PHYSICAL THERAPY		1341222						50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P		2950666						55
56	DRUGS CHARGED TO PATIENTS		2447664						56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		4319055						61
62	OBSERVATION BEDS (NON-DISTINC		104573						62
63.50	RHC								63.50
63.51	RHC II								63.51
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL		23324180						101

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

CHECK APPLICABLE BOXES	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ] PPS
	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ] TEFRA
	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ] OTHER
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO P						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
101	TOTAL						101

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1 PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1316) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF (PPS) (14-5470) 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3343					27113	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1232					27113	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1232					27113	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	321						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	810						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	171						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	809						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	769					452	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	321						10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	810						11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST — WORKSHEET D-1, PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF (PPS) (14-5470)	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	96.62						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1711764					3184943	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16522						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	80002						25
26	TOTAL SWING-BED COST	869619						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	842145					3184943	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	761434					3403144	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	761434					3403144	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.105999					.935883	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	618.05					125.52	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	842145					3184943	37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	683.55					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	525650					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	525650					41

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

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	345680					48
49	TOTAL PROGRAM INPATIENT COSTS	871330					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1316) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	219420	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	553676	61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	773096	62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS		65

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

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

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

		SNF (PPS) (14-5470) 1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST	3184943	66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	117.47	67
68	PROGRAM ROUTINE SERVICE COST	53096	68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	53096	70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	341789	71
72	PER DIEM CAPITAL RELATED COSTS	12.61	72
73	PROGRAM CAPITAL RELATED COSTS	5700	73
74	INPATIENT ROUTINE SERVICE COST	47396	74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	47396	76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78	INPATIENT ROUTINE SERVICE COST LIMITATION		78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	53096	79
80	PROGRAM INPATIENT ANCILLARY SERVICES	38252	80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	91348	82

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

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

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	47					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	683.56					84
85 OBSERVATION BED COST	32127					85

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	NF	
	INPATIENT DAYS	1	1	1	1	1	1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3343						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1232						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1232						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	321						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	810						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	171						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	809						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	51						9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	NF	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	96.62						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1711764						21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16522						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	80002						25
26	TOTAL SWING-BED COST	869619						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	842145						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	761434						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	761434						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.105999						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	618.05						33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	842145						37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	683.55					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	34861					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	34861					41

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

		HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49	TOTAL PROGRAM INPATIENT COSTS	34861					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	2521					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST	2521					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1316) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

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

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

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

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

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

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	47					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	683.56					84
85 OBSERVATION BED COST	32127					85

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1316)	[ ] SNF	[ ] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		422540		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.299482	30263	9063	37
40	ANESTHESIOLOGY	16.256184			40
41	RADIOLOGY-DIAGNOSTIC	.285895	135125	38632	41
44	LABORATORY	.288767	268820	77626	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.105218	185450	19513	49
50	PHYSICAL THERAPY	.376920	25416	9580	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.066040	225006	14859	55
56	DRUGS CHARGED TO PATIENTS	.247136	598901	148010	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.436433	65067	28397	61
62	OBSERVATION BEDS (NON-DISTINCT	.307221			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.51	RHC II				63.51
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		1534048	345680	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		1534048		103

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[ ] HOSPITAL	[XX] SNF (14-5470)	[XX] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[ ] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.299482			37
40	ANESTHESIOLOGY	16.256184			40
41	RADIOLOGY-DIAGNOSTIC	.285895	3329	952	41
44	LABORATORY	.288767	4177	1206	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.105218	15682	1650	49
50	PHYSICAL THERAPY	.376920	33724	12711	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.066040	14753	974	55
56	DRUGS CHARGED TO PATIENTS	.247136	83999	20759	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.436433			61
62	OBSERVATION BEDS (NON-DISTINCT	.307221			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.51	RHC II				63.51
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		155664	38252	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		155664		103

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[ ] HOSPITAL	[ ] SNF	[ ] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[XX] S/B-SNF (14-Z316)	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.299482			37
40	ANESTHESIOLOGY	16.256184			40
41	RADIOLOGY-DIAGNOSTIC	.285895	19210	5492	41
44	LABORATORY	.288767	33070	9550	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.105218	24259	2552	49
50	PHYSICAL THERAPY	.376920	306326	115460	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.066040	126529	8356	55
56	DRUGS CHARGED TO PATIENTS	.247136	261346	64588	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.436433	436	190	61
62	OBSERVATION BEDS (NON-DISTINCT	.307221			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.51	RHC II				63.51
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		771176	206188	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		771176		103

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1316)	[ ] SNF	[ ] PPS
[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[XX] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.299482			37
40	ANESTHESIOLOGY	16.256184			40
41	RADIOLOGY-DIAGNOSTIC	.285895			41
44	LABORATORY	.288767			44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.105218			49
50	PHYSICAL THERAPY	.376920			50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.066040			55
56	DRUGS CHARGED TO PATIENTS	.247136			56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.436433			61
62	OBSERVATION BEDS (NON-DISTINCT	.307221			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC				63.50
63.51	RHC II				63.51
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL				101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES				103

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS (CONT)

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS — (CONT)

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02	
1	MEDICAL AND OTHER SERVICES	1785828			1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST	1785828			5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES	1803686			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	14548			18
18.01	COINSURANCE	1061965			18.01
19	SUBTOTAL	727173			19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL	727173			23
24	PRIMARY PAYER PAYMENTS	244			24
25	SUBTOTAL	726929			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	263664			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	263664			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	263664			27.02
28	SUBTOTAL	990593			28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL	990593			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1131196			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	-140603			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	16513			36

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF (14-5470) 1	SNF (14-5470) 1.01	SNF (14-5470) 1.02	
1	MEDICAL AND OTHER SERVICES				1
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03	1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04	LINE 1.01 TIMES LINE 1.03				1.04
1.05	LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06	TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07	AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2	INTERNS AND RESIDENTS				2
3	ORGAN ACQUISITIONS				3
4	COST OF TEACHING PHYSICIANS				4
5	TOTAL COST				5
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6	ANCILLARY SERVICE CHARGES				6
7	INTERNS AND RESIDENTS SERVICE CHARGES				7
8	ORGAN ACQUISITION CHARGES				8
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10	TOTAL REASONABLE CHARGES				10
	CUSTOMARY CHARGES				
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13	RATIO OF LINE 11 TO LINE 12				13
14	TOTAL CUSTOMARY CHARGES				14
15	EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17	LESSER OF COST OR CHARGES				17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF (14-5470) 1	SNF (14-5470) 1.01	SNF (14-5470) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES				18
18.01	COINSURANCE				18.01
19	SUBTOTAL				19
20	SUM OF AMOUNTS FROM WKST E, PARTS C,D & E				20
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				21
22	ESRD DIRECT MEDICAL EDUCATION COSTS				22
23	SUBTOTAL				23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL				25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS				27
27.01	REDUCED REIMBURSABLE BAD DEBTS				27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28	SUBTOTAL				28
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				29
30	OTHER ADJUSTMENTS				30
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)				30.99
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				31
32	SUBTOTAL				32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS				34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM				35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

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

		HOSPITAL (14-1316) OCTOBER 1, 1997 PRIOR TO 1	ON OR AFTER 1.01	
1	STANDARD OVERHEAD AMOUNTS (ASC FEES)			1
2	DEDUCTIBLES			2
3	SUBTOTAL			3
4	80 PERCENT OF LINE 3			4
5	ASC PORTION OF BLEND			5
6	OUTPATIENT ASC COST			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	HOSPITAL SPECIFIC PORTION OF BLEND			17
18	ASC BLENDED AMOUNT			18
19	LESSER OF LINES 16 OR 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	ASC PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

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

		HOSPITAL (14-1316) OCTOBER 1, 1997		
		PRIOR TO	ON OR AFTER	
		1	1.01	
1	PREVAILING CHARGES			1
2	62 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OUTPATIENT RADIOLOGY			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	RADIOLOGY PAYMENT AMOUNT			21

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

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

		HOSPITAL (14-1316) OCTOBER 1, 1997		
		PRIOR TO	ON OR AFTER	
		1	1.01	
1	PREVAILING CHARGES			1
2	42 PERCENT OF LINE 1			2
3	DEDUCTIBLES			3
4	SUBTOTAL			4
5	BLENDED CHARGE PROPORTION			5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES			6
	COMPUTATION OF LESSER OF COST OR CHARGES			
7	TOTAL CHARGES			7
	CUSTOMARY CHARGES			
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)			9
10	RATIO OF LINE 8 TO LINE 9			10
11	TOTAL CUSTOMARY CHARGES			11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			13
14	LESSER OF COST OR CHARGES			14
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
15	DEDUCTIBLES AND COINSURANCE			15
16	TOTAL			16
17	COST PROPORTION			17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT			18
19	LESSER OF LINE 16 OR LINE 18			19
20	PART B DEDUCTIBLES AND COINSURANCE			20
21	DIAGNOSTIC PAYMENT AMOUNT			21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — WORKSHEET E-1

HOSPITAL (14-1316)

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				446238		1027995	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM		.01	09/23/2008	40105	09/23/2008	115776	3.01
	ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM	.02					3.02
	REVISION OF THE INTERIM RATE FOR THE COST	TO	.03					3.03
	REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER	.04					3.04
	PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.05					3.05
			.50			09/23/2008	12575	3.50
		PROVIDER	.51					3.51
		TO	.52		NONE			3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99		40105		103201	3.99
4	TOTAL INTERIM PAYMENTS				486343		1131196	4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY-	PROGRAM	.01					5.01
	MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH	TO	.02					5.02
	PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT	PROGRAM TO PROVIDER	.01					6.01
	(BALANCE DUE) BASED ON THE COST REPORT.	PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — WORKSHEET E-1

SKILLED NURSING FACILITY I (14-5470)

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				121317			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
		PROGRAM TO	.02					3.02
			.03		NONE		NONE	3.03
		PROVIDER	.04					3.04
			.05					3.05
			.50					3.50
		PROVIDER TO	.51					3.51
			.52		NONE		NONE	3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99					3.99
4	TOTAL INTERIM PAYMENTS				121317			4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO	.01					5.01
			.02					5.02
		PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		PROVIDER TO	.51					5.51
		PROGRAM	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — WORKSHEET E-1

SWING BED SKILLED NURSING FACILITY (14-Z316)

	DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				743878			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
		PROGRAM TO	.02					3.02
			.03		NONE		NONE	3.03
		PROVIDER	.04					3.04
			.05					3.05
			.50	09/17/2008	52687			3.50
		PROVIDER	.51					3.51
		TO	.52				NONE	3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99		-52687			3.99
4	TOTAL INTERIM PAYMENTS				691191			4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO	.01					5.01
			.02					5.02
		PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		TO	.51					5.51
		PROGRAM	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY							7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

SUPPLEMENTAL
WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

		TITLE V S/B NF	--- TITLE XVIII --- S/B SNF PART A (14-Z316)	S/B SNF PART B (14-Z316)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		780827				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		208250				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		1131				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		989077				8
9	PRIMARY PAYER PAYMENTS		10000				9
10	SUBTOTAL		979077				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		979077				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		30056				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		949021				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)						17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						17.01
18	TOTAL		949021				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		691191				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		257830				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		7903				22

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	871330						1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)							1.01
2	ORGAN ACQUISITION							2
3	COST OF TEACHING PHYSICIANS							3
4	SUBTOTAL	871330						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	880043						6
	COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES							
7	ROUTINE SERVICE CHARGES							7
8	ANCILLARY SERVICE CHARGES							8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE							9
10	TEACHING PHYSICIANS							10
11	TOTAL REASONABLE CHARGES							11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS							12
13	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(E)							13
14	RATIO OF LINE 12 TO LINE 13							14
15	TOTAL CUSTOMARY CHARGES							15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							17

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							18
19	COST OF COVERED SERVICES	880043						19
20	DEDUCTIBLES	217795						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	662248						22
23	COINSURANCE							23
24	SUBTOTAL	662248						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	23100						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	23100						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	23100						25.02
26	SUBTOTAL	685348						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	LOSS ON SALE OF ASSETS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	685348						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	486343						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	199005						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	7913						34

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

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

		SNF I (14-5470) (PPS) 2	
	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL/SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES		2
3	INTERNS AND RESIDENTS		3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS ONLY		4
5	COST OF TEACHING PHYSICIANS		5
6	SUBTOTAL		6
7	INPATIENT PRIMARY PAYER PAYMENTS		7
8	OUTPATIENT PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL		9
	COMPUTATION OF LESSER OF COST OR CHARGES		
10	ROUTINE SERVICE CHARGES		10
11	ANCILLARY SERVICE CHARGES		11
12	INTERNS AND RESIDENTS SERVICE CHARGES		12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		13
14	TEACHING PHYSICIANS		14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		15
16	TOTAL REASONABLE CHARGES		16
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		17
18	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)		18
19	RATIO OF LINE 17 TO LINE 18		19
20	TOTAL CUSTOMARY CHARGES		20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		22
23	COST OF COVERED SERVICES		23
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS	139865	24
25	OUTLIER PAYMENTS		25
26	PROGRAM CAPITAL PAYMENTS		26
27	CAPITAL EXCEPTION PAYMENTS		27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		29
30	SUBTOTAL	139865	30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		31
32	AMOUNT FROM LINE 30	139865	32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		33

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

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

		SNF I (14-5470) (PPS) 2	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		34
35	SUBTOTAL	139865	35
36	COINSURANCE	18548	36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19		37
38	REIMBURSABLE BAD DEBTS	16716	38
38.01	REDUCED REIMBURSABLE BAD DEBTS		38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	16716	38.02
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.)	16716	38.03
39	UTILIZATION REVIEW		39
40	SUBTOTAL	138033	40
41	INPATIENT ROUTINE SERVICE COST		41
42	MEDICARE INPATIENT ROUTINE CHARGES		42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		43
44	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)		44
45	RATIO OF LINE 43 TO LINE 44		45
46	TOTAL CUSTOMARY CHARGES		46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		49
50	LOSS ON SALE OF ASSETS		50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		51
52	SUBTOTAL	138033	52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	138033	55
56	SEQUESTRATION ADJUSTMENT		56
57	INTERIM PAYMENTS	121317	57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)		57.01
58	BALANCE DUE PROVIDER/PROGRAM	16716	58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		59

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

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

		HOSPITAL (14-1316) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (PPS)	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	34861						1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	34861						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	34861						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES							11
12	INTERNS AND RESIDENTS SERVICE CHARGES							12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE							13
14	TEACHING PHYSICIANS							14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION							15
16	TOTAL REASONABLE CHARGES							16
	CUSTOMARY CHARGES							
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							18
19	RATIO OF LINE 17 TO LINE 18							19
20	TOTAL CUSTOMARY CHARGES							20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							22
23	COST OF COVERED SERVICES	34861						23
	PROSPECTIVE PAYMENT AMOUNT							
24	OTHER THAN OUTLIER PAYMENTS							24
25	OUTLIER PAYMENTS							25
26	PROGRAM CAPITAL PAYMENTS							26
27	CAPITAL EXCEPTION PAYMENTS							27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS							28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS							29
30	SUBTOTAL	34861						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31	34861						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

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

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

		HOSPITAL (14-1316) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST							34
35	SUBTOTAL	34861						35
36	COINSURANCE							36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,							37
38	REIMBURSABLE BAD DEBTS							38
38.01	REDUCED REIMBURSABLE BAD DEBTS							38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							38.02
39	UTILIZATION REVIEW							39
40	SUBTOTAL	34861						40
41	INPATIENT ROUTINE SERVICE COST							41
42	MEDICARE INPATIENT ROUTINE CHARGES							42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							44
45	RATIO OF LINE 43 TO LINE 44							45
46	TOTAL CUSTOMARY CHARGES							46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							49
50	LOSS ON SALE OF ASSETS							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL	34861						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	34861						55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM	34861						58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							59

BALANCE SHEET WORKSHEET G

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	-145071				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3390549				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1549000				6
7	INVENTORY	140827				7
8	PREPAID EXPENSES	50674				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS	145071				10
11	TOTAL CURRENT ASSETS	2033050				11
	FIXED ASSETS					
12	LAND	208100				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS					13
13.01	ACCUMULATED DEPRECIATION					13.01
14	BUILDINGS	9339958				14
14.01	ACCUMULATED DEPRECIATION	-2724458				14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT					16
16.01	ACCUMULATED DEPRECIATION					16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT	3503846				18
18.01	ACCUMULATED DEPRECIATION	-2501642				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	7825804				21
	OTHER ASSETS					
22	INVESTMENTS	5470937				22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	90935				25
26	TOTAL OTHER ASSETS	5561872				26
27	TOTAL ASSETS	15420726				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1191419				28
29	SALARIES, WAGES & FEES PAYABLE	1012653				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	1006281				35
36	TOTAL CURRENT LIABILITIES	3210353				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	7505141				37
38	NOTES PAYABLE					38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES	1251681				41
42	TOTAL LONG TERM LIABILITIES	8756822				42
43	TOTAL LIABILITIES	11967175				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	3453551				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	3453551				51
52	TOTAL LIABILITIES AND FUND BALANCES	15420726				52

STATEMENT OF CHANGES IN FUND BALANCES — WORKSHEET G-1

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD	3069635				1
2	NET INCOME (LOSS)	383916				2
3	TOTAL	3453551				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	3453551				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	3453551				19

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	760970		760970	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	285642		285642	4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY	3656151		3656151	6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	4702763		4702763	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	INTENSIVE CARE UNIT				10
11	CORONARY CARE UNIT				11
12	BURN INTENSIVE CARE UNIT				12
13	SURGICAL INTENSIVE CARE UNIT				13
14	OTHER SPECIAL CARE (SPECIFY)				14
15	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16	TOTAL INPATIENT ROUTINE CARE SERVICES	4702763		4702763	16
17	ANCILLARY SERVICES	4664535	17200682	21865217	17
18	OUTPATIENT SERVICES				18
18.50	RHC		1346733	1346733	18.50
18.51	RHC II				18.51
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE		962973	962973	20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24	PROFESSIONAL FEES		155141	155141	24
24.01	ASSISTED LIVING		2272093	2272093	24.01
25	TOTAL PATIENT REVENUES	9367298	21937622	31304920	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		15489930	26
27	ADD (SPECIFY)			27
28	BAD DEBTS	2168422		28
29	OTHER	5930		29
30				30
31				31
32				32
33	TOTAL ADDITIONS		2174352	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		17664282	40

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	31304920	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	14519431	2
3	NET PATIENT REVENUES	16785489	3
4	LESS - TOTAL OPERATING EXPENSES	17664282	4
5	NET INCOME FROM SERVICE TO PATIENTS	-878793	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	114320	6
7	INCOME FROM INVESTMENTS	-1309	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	43308	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	3969	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	476	21
22	RENTAL OF HOSPITAL SPACE	9090	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TRUST INCOME	90065	24
24.01	MISCELLANEOUS INCOME	22818	24.01
24.02	UNREALIZED GAINS		24.02
24.03	GRANTS	24342	24.03
24.04	CATERING	11286	24.04
24.05	MEDICAID ASSESSMENT REVENUE	487579	24.05
24.06	COUNTY TERRACE	456765	24.06
25	TOTAL OTHER INCOME	1262709	25
26	TOTAL	383916	26
27	LOSS ON DISPOSAL		27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	383916	31

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

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES A						22
23	I&R SERVICES-OTHER PRGM COSTS A						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
34	SKILLED NURSING FACILITY						34
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN CO						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO PAT						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
96	GIFT, FLOWER, COFFEE SHOP & CAN						96
98	PHYSICIANS' PRIVATE OFFICES						98
99.01	ASSISTED LIVING						99.01
00	FOUNDATION						00
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

RHC I WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT NO: 14-3448

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	452152		452152		452152		452152	1
2	PHYSICIAN ASSISTANT	150491		150491		150491		150491	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	132375		132375		132375		132375	9
10	SUBTOTAL (SUM OF LINES 1-9)	735018		735018		735018		735018	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES								15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		109931	109931	-6407	103524		103524	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		109931	109931	-6407	103524		103524	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	735018	109931	844949	-6407	838542		838542	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD								31
32	TOTAL FACILITY COSTS	735018	109931	844949	-6407	838542		838542	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3448

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	2.00	9411	4200	8400		1
2	PHYSICIAN ASSISTANTS	1.22	3219	2100	2562		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	3.22	12630		10962	12630	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	3.22	12630			12630	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	838542	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	838542	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	779518	15
16	TOTAL OVERHEAD	779518	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	779518	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	779518	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1618060	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3448

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1618060	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1618060	3
4	TOTAL VISITS	12630	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	12630	6
7	ADJUSTED COST PER VISIT	128.11	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	128.11	128.11		9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	1334	1293		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	170899	165646		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES				14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST				15
16	TOTAL PROGRAM COST			336545	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			27276	17
18	NET PROGRAM COST EXCLUDING VACCINES			309269	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			247415	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION				20
21	TOTAL REIMBURSABLE PROGRAM COST			247415	21
22	REIMBURSABLE BAD DEBTS				22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			247415	24
25	INTERIM PAYMENTS			249924	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			-2509	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC I

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3448

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

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	735018	735018	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE			5
6	TOTAL DIRECT COST OF THE FACILITY	838542	838542	6
7	TOTAL OVERHEAD	779518	779518	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I COMPONENT NO: 14-3448

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				249924	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01			3.01
	PROGRAM TO PROVIDER	.02			3.02
		.03		NONE	3.03
		.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER TO PROGRAM	.51			3.51
		.52		NONE	3.52
		.53			3.53
		.54			3.54
SUBTOTAL		.99			3.99
4 TOTAL INTERIM PAYMENTS				249924	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01			5.01
		.02			5.02
	PROVIDER TO PROGRAM	.03			5.03
		.50			5.50
		.51			5.51
		.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

RHC II WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT NO: 14-3485

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN								1
2	PHYSICIAN ASSISTANT	21736		21736		21736		21736	2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (SUM OF LINES 1-9)	21736		21736		21736		21736	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT								11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (SUM OF LINES 11-13)								14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES								15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		16431	16431	-3933	12498		12498	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		16431	16431	-3933	12498		12498	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	21736	16431	38167	-3933	34234		34234	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD								31
32	TOTAL FACILITY COSTS	21736	16431	38167	-3933	34234		34234	32

RHC II WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT NO: 14-3485

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	0.02	388	4200	84		1
2	PHYSICIAN ASSISTANTS	0.21	190	2100	441		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	0.23	578		525	578	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	0.23	578			578	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	34234	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	34234	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	8364	15
16	TOTAL OVERHEAD	8364	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	8364	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	8364	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	42598	20

RHC II WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3485

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	42598	1
2	COST OF VACCINES AND THEIR ADMINISTRATION		2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	42598	3
4	TOTAL VISITS	578	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	578	6
7	ADJUSTED COST PER VISIT	73.70	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	73.70	73.70		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	35	26		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	2580	1916		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES				14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST				15
16	TOTAL PROGRAM COST			4496	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			757	17
18	NET PROGRAM COST EXCLUDING VACCINES			3739	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			2991	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION				20
21	TOTAL REIMBURSABLE PROGRAM COST			2991	21
22	REIMBURSABLE BAD DEBTS				22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			2991	24
25	INTERIM PAYMENTS			2974	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			17	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

RHC II

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3485

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

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	21736	21736	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE			5
6	TOTAL DIRECT COST OF THE FACILITY	34234	34234	6
7	TOTAL OVERHEAD	8364	8364	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION			16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC II COMPONENT NO: 14-3485

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

DESCRIPTION			PART B 1 MM/DD/YYYY	PART B 2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				2974	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01			3.01
	PROGRAM	.02			3.02
	TO	.03		NONE	3.03
	PROVIDER	.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER	.51			3.51
	TO	.52		NONE	3.52
	PROGRAM	.53			3.53
		.54			3.54
SUBTOTAL		.99			3.99
4 TOTAL INTERIM PAYMENTS				2974	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
	TO	.02			5.02
	PROVIDER	.03			5.03
	PROVIDER	.50			5.50
	TO	.51			5.51
	PROGRAM	.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

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

	COST CENTERS	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	62.42		4.14				66.56	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	0.90	38.38					39.28	37
41	RADIOLOGY-DIAGNOSTIC	3.34	30.41					33.75	41
44	LABORATORY	8.40	27.53					35.93	44
49	RESPIRATORY THERAPY	11.83	32.45					44.28	49
50	PHYSICAL THERAPY	1.89	17.18					19.07	50
55	MEDICAL SUPPLIES CHARGED TO PAT	7.63	10.58					18.21	55
56	DRUGS CHARGED TO PATIENTS	24.47	26.55					51.02	56
61	EMERGENCY	1.51	24.62					26.13	61
62	OBSERVATION BEDS (NON-DISTINCT		28.36					28.36	62
101	TOTAL CHARGES	5.32	21.48					26.80	101

***** REPORT 97 ***** UTILIZATION STATISTICS ***** SNF / NF

	COST CENTERS	SNF TITLE XVIII PART A 1	SNF TITLE XVIII PART B 2	NF TITLE XIX INPATIENT 3	NF TITLE XIX OUTPATIENT 4	NF TITLE V INPATIENT 5	NF TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
34	SKILLED NURSING FACILITY	1.67						1.67	34
UTILIZATION PERCENTAGES BASED ON CHARGES									
41	RADIOLOGY-DIAGNOSTIC	0.08						0.08	41
44	LABORATORY	0.13						0.13	44
49	RESPIRATORY THERAPY	1.00						1.00	49
50	PHYSICAL THERAPY	2.51						2.51	50
55	MEDICAL SUPPLIES CHARGED TO PAT	0.50						0.50	55
56	DRUGS CHARGED TO PATIENTS	3.43						3.43	56
101	TOTAL CHARGES	0.54						0.54	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	852490	5.78	-852490	-12.80			3
4	NEW CAP REL COSTS-MVBLE EQUIP	608162	4.13	-608162	-9.13			4
5	EMPLOYEE BENEFITS	825975	5.60	-825975	-12.40			5
6	ADMINISTRATIVE & GENERAL	2346952	15.92	-2346952	-35.24			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	595032	4.04	-595032	-8.94			8
9	LAUNDRY & LINEN SERVICE	123657	.84	-123657	-1.86			9
10	HOUSEKEEPING	310372	2.11	-310372	-4.66			10
11	DIETARY	618621	4.20	-618621	-9.29			11
12	CAFETERIA							12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	102104	.69	-102104	-1.53			14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY	223030	1.51	-223030	-3.35			17
18	SOCIAL SERVICE	52710	.36	-52710	-.79			18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A							22
23	I&R SERVICES-OTHER PRGM COSTS A							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	947086	6.43	764678	11.48	1711764	11.61	25
34	SKILLED NURSING FACILITY	1362309	9.24	1822634	27.37	3184943	21.61	34
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	702507	4.77	300838	4.52	1003345	6.81	37
40	ANESTHESIOLOGY	13812	.09	4590	.07	18402	.12	40
41	RADIOLOGY-DIAGNOSTIC	718026	4.87	437575	6.57	1155601	7.84	41
44	LABORATORY	619136	4.20	305011	4.58	924147	6.27	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	83239	.56	81662	1.23	164901	1.12	49
50	PHYSICAL THERAPY	367035	2.49	138498	2.08	505533	3.43	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO PAT	131760	.89	63101	.95	194861	1.32	55
56	DRUGS CHARGED TO PATIENTS	469987	3.19	134920	2.03	604907	4.10	56
61	EMERGENCY	1270488	8.62	614489	9.23	1884977	12.79	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RHC	838542	5.69	779518	11.71	1618060	10.98	63.50
63.51	RHC II	34234	.23	8364	.13	42598	.29	63.51
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	365593	2.48	136320	2.05	501913	3.41	65
	OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC							69.10

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			39980	.60	39980	.27	96
98	PHYSICIANS' PRIVATE OFFICES			3226	.05	3226	.02	98
99.01	ASSISTED LIVING	155671	1.06	1023574	15.37	1179245	8.00	99.01
100	FOUNDATION	522		127		649		100
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	14739052	100.00	0	.00	14739052	100.00	103

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	1698968
2.	TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	5960004
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.285