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 HAMILTON MEMORIAL HOSPITAL (14-1326) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2007 AND ENDING 06/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(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		126608	-250369		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-4587			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	RURAL HEALTH CLINIC I			42050		9
100	TOTAL		122021	-208319		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: 611 SOUTH MARSHALL P.O.BOX: 1
1.01 CITY: MCLEANSBORO STATE: IL ZIP CODE: 62859 COUNTY: HAMILTON 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	HAMILTON MEMORIAL HOSPITAL	14-1326	05/01/2003	N	O	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	HAMILTON MEMORIAL HOSP SWING BED	14-Z326	05/01/2003	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA	HAMILTON MEMORIAL HHA	14-7167	11/13/1978	N	P	N	9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	HAMILTON MEMORIAL FAMILY CLINIC	14-3477	01/11/2006	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 07/01/2007	TO: 06/30/2008	17
		1	2	
18	TYPE OF CONTROL	11		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
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)			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)			25.06

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

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	09/24/1984		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
28.03	STAFFING	0.00	N		28.03
28.04	RECRUITMENT	0.00	N		28.04
28.05	RETENTION OF EMPLOYEES	0.00	N		28.05
28.06	TRAINING	0.00	N		28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	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).	YES			31

MISCELLANEOUS COST REPORTING INFORMATION

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

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

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

TITLE XIX INPATIENT HOSPITAL SERVICES

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

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

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
		1	2	3	4	5	
47	HOSPITAL	Y	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:							54
	PREMIUMS: 156646 PAID LOSSES: AND/OR SELF INSURANCE:							
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.				NO			54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.				NO			55

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

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

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

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

MULTICAMPUS

61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	61

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.

	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	BED DAYS AVAILABLE	CAH PATIENT HOURS	I/P DAYS / O/P VISITS / TRIPS TITLE V	TITLE XVIII	LTCH NONCOVERED DAYS	TITLE XIX	OBS. BEDS ADMITTED	
		1	2	2.01	3	4	4.01	5	5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9150	77856.00		2412		291		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					692				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9150	77856.00		3104		291		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	25	9150	77856.00		3104		291		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY	60	21960							16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY					2024				18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I							1394		24
25	TOTAL	85								25
26	OBSERVATION BED DAYS							176	31	26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

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

	COMPONENT	I/P DAYS OBS. BEDS NOT ADMITTED 5.02	I/P DAYS TOTAL ALL PATIENTS 6	O/P VISITS OBS. BEDS ADMITTED 6.01	TRIPS OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		3073								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		692								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		32								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3797								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		3797						115.35		12
13	RPCH VISITS										13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY										15
16	NURSING FACILITY		19908						56.09		16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY		2396						4.92		18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I		5325						7.83		24
25	TOTAL								184.19		25
26	OBSERVATION BED DAYS	145	907	268	639						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		789	133	1077	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		789	133	1077	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION — WORKSHEET S-3 PART II

	PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	SALARIES	1	2	3	4	5	6	
1	TOTAL SALARIES	6405078						1
2	NON-PHYSICIAN ANESTHETIST PART A	229127			2360.00			2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B	375815			4160.00			5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	1500377						8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	81369			1507.00			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)	801089					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	508821					CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A	77232					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	127205					CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	648880	1872		35322.23			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	141632			9159.45			24
25	LAUNDRY & LINEN SERVICE	71823			8177.55			25
26	HOUSEKEEPING	99857			11390.96			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	14830	-1872		894.77			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	242346			11025.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY	173254			4217.77			32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	140222			8952.75			33
34	SOCIAL SERVICE	37239			2227.75			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	5800136		5800136	-6520.00	-889.59	1
2	EXCLUDED AREA SALARIES	1500377		1500377			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	4299759		4299759	-6520.00	-659.47	3
4	SUBTOTAL OTHER WAGES & REL COSTS	81369		81369	1507.00	53.99	4
5	SUBTOTAL WAGE-RELATED COSTS	801089		801089		18.63%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	5182217		5182217	-5013.00	-1033.76	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	1570083		1570083	91368.23	17.18	13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA HHA NO.: 14-7167 WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS				8	8	1
2	UNDUPLICATED CENSUS COUNT		95.00		14.00	109.00	2

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

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: .00	STAFF 1	CONTRACT 2	TOTAL 3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	.90		.90	3
4	DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	1.02		1.02	5
6	DIRECT NURSING SERVICE	2.21		2.21	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	.79		.79	8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE				10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE				12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE				14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE				16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

			1	1.01	
19	HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD		1	1	19
20	LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE)		9914	99914	20

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA HHA NO.: 14-7167 WORKSHEET S-4 (CONTINUED)

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

		FULL EPISODES WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL 7	
21	SKILLED NURSING VISITS	1012		20	8		29	1069	21
22	SKILLED NURSING VISIT CHARGES	111335		2161	910		3184	117590	22
23	PHYSICAL THERAPY VISITS	749			11		7	767	23
24	PHYSICAL THERAPY VISIT CHARGES	82380			1216		774	84370	24
25	OCCUPATIONAL THERAPY VISITS	150					3	153	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	16456					374	16830	26
27	SPEECH PATHOLOGY VISITS	35						35	27
28	SPEECH PATHOLOGY VISIT CHARGES	3850						3850	28
29	MEDICAL SOCIAL SERVICE VISITS								29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES								30
31	HOME HEALTH AIDE VISITS								31
32	HOME HEALTH AIDE VISIT CHARGES								32
33	TOTAL VISITS	1946		20	19		39	2024	33
34	OTHER CHARGES								34
35	TOTAL CHARGES	214021		2161	2126		4332	222640	35
36	TOTAL NUMBER OF EPISODES	40		8	1		1	50	36
37	TOTAL NUMBER OF OUTLIER EPISODES								37
38	TOTAL MEDICAL SUPPLY CHARGES	4111		6	6		81	4204	38

NHCMQ DEMONSTRATION STATISTICAL DATA WORKSHEET S-7
STATISTICAL DATA

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

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3477

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 611 SOUTH MARSHALL					1
1.01	CITY: MCLEANSBORO	STATE: IL	ZIP CODE: 62859	COUNTY: HAMILTON		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	ASUNCION COPE MD	L21550	9
9.01		RENE TROTTER NP	K23480	9.01
9.02		ROBERT VERGARA MD	K28175	9.02

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

11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 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)	NO	11

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION 0	FROM 1	TO 2	FROM 3	TO 4	FROM 5	TO 6	FROM 7	TO 8	FROM 9	TO 10	FROM 11	TO 12	FROM 13	TO 14	
12	CLINIC			900	1700	900	1700	900	1700	900	1700	900	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)? 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 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
3	0300	NEW CAP REL COSTS-BLDG & FIXT		239147	239147	11879	251026	-60913	190113	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		453178	453178	78275	531453		531453	4
5	0500	EMPLOYEE BENEFITS		1514347	1514347		1514347	-36468	1477879	5
6.01	0610	NONPATIENT TELEPHONES		28176	28176	-4226	23950		23950	6.01
6.02	0620	DATA PROCESSING	59401	23983	83384		83384		83384	6.02
6.03	0630	PURCHASING RECEIVING AND STORES	39491	3861	43352		43352	-242	43110	6.03
6.04	0640	ADMITTING				113922	113922		113922	6.04
6.05	0650	CASHIERING/ACCOUNTS RECEIVABLE	175619	186846	362465	-113922	248543		248543	6.05
6.06	0660	OTHER ADMINISTRATIVE AND GENERA	374369	376364	750733	204746	955479	-315489	639990	6.06
8	0800	OPERATION OF PLANT	141632	303692	445324	-12366	432958		432958	8
9	0900	LAUNDRY & LINEN SERVICE	71823	39878	111701		111701		111701	9
10	1000	HOUSEKEEPING	99857	22078	121935		121935		121935	10
11	1100	DIETARY	14830	76906	91736	-11578	80158		80158	11
12	1200	CAFETERIA								12
14	1400	NURSING ADMINISTRATION	242346	9072	251418		251418		251418	14
15	1500	CENTRAL SERVICES & SUPPLY		14899	14899	-7520	7379		7379	15
16	1600	PHARMACY	173254	433605	606859	-394112	212747		212747	16
17	1700	MEDICAL RECORDS & LIBRARY	140222	32228	172450		172450	-4059	168391	17
18	1800	SOCIAL SERVICE	37239	4950	42189		42189		42189	18
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	1216231	87097	1303328		1303328		1303328	25
35	3500	NURSING FACILITY	1271252	270870	1542122	24388	1566510	-9230	1557280	35
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	138067	145698	283765	-117793	165972		165972	37
40	4000	ANESTHESIOLOGY	229127	38162	267289	-8293	258996		258996	40
41	4100	RADIOLOGY-DIAGNOSTIC	285416	222040	507456	-2400	505056		505056	41
44	4400	LABORATORY	323676	426824	750500		750500		750500	44
49	4900	RESPIRATORY THERAPY	128695	23699	152394	-2878	149516		149516	49
50	5000	PHYSICAL THERAPY	263209	96185	359394		359394		359394	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY		3648	3648		3648		3648	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				113622	113622	-12672	100950	55
56	5600	DRUGS CHARGED TO PATIENTS				367575	367575	-40615	326960	56
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	161663	622298	783961	67589	851550	-217465	634085	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC	588534	100599	689133	-102297	586836	-101819	485017	63.50
		OTHER REIMBURSABLE COST CENTERS								
71	7100	HOME HEALTH AGENCY	229125	84305	313430	1026	314456	-692	313764	71
		SPECIAL PURPOSE COST CENTERS								
88	8800	INTEREST EXPENSE		28635	28635	-28635				88
90	9000	OTHER CAPITAL RELATED COSTS		25099	25099	-25099				90
94	6950	OTHER SPECIAL PURPOSE COST CENT								94
94.01	6951	INSURANCE AND MALPRACTICE		144419	144419	-144419				94.01
94.02	6952	SUPPLIES AND EXPENSE		7484	7484	-7484				94.02
95		SUBTOTALS	6405078	6090272	12495350		12495350	-799664	11695686	95
		NONREIMBURSABLE COST CENTERS								
98	9800	PHYSICIANS' PRIVATE OFFICES		68189	68189		68189		68189	98
101		TOTAL	6405078	6158461	12563539		12563539	-799664	11763875	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		28635	1
2	TO RECLASS CAFETERIA COSTS	B	OTHER ADMINISTRATIVE AND GENE	6.06	1872	9706	2
3	TO RECLASS RENT EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		98269	3
4		C					4
5		C					5
6		C					6
7		C					7
8		C					8
9	TO RECLASS INSURANCE EXPENSE	D	OTHER ADMINISTRATIVE AND GENE	6.06		179306	9
10		D					10
11		D					11
12	TO RECLASS SALARIES & OTHER EXP	E	ADMITTING	6.04	58481	55441	12
13	TO RECLASS SUPPLIES SOLD TO PATIENTS	F	MEDICAL SUPPLIES CHARGED TO P	55		113622	13
14		F					14
15		F					15
16		F					16
17		F					17
18		F					18
19	TO RECLASS DRUGS TO PHARMACY	G	DRUGS CHARGED TO PATIENTS	56		352189	19
20	TO RECLASS SUPPLIES SOLD	H	CENTRAL SERVICES & SUPPLY	15		7484	20
21	TO RECLASS NURSING CENTER PHONES	I	NURSING FACILITY	35		4226	21
22	TO RECLASS NURSING CENTER DEPRECIATI	J	NURSING FACILITY	35		47054	22
23		J					23
24	TO RECLASS IV COSTS	K	DRUGS CHARGED TO PATIENTS	56		15386	24
25	TO RECLASS AUDIT COST	L	OTHER ADMINISTRATIVE AND GENE	6.06		5774	25
26		L					26
27	TO RECLASS HHA DEPRECIATION	M	HOME HEALTH AGENCY	71		14795	27
28	TO RECLASS MALPRACTICE INSURANCE	N	OTHER ADMINISTRATIVE AND GENE	6.06		28463	28
29	TO RECLASS ER TIME FOR RHC PHYS	O	EMERGENCY	61	73810		29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				134163	960350	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		28635	11	1
2	TO RECLASS CAFETERIA COSTS	B	DIETARY	11	1872	9706		2
3	TO RECLASS RENT EXPENSE	C	OTHER ADMINISTRATIVE AND GENE	6.06		20375	10	3
4		C	OPERATING ROOM	37		35110		4
5		C	RESPIRATORY THERAPY	49		1481		5
6		C	RADIOLOGY-DIAGNOSTIC	41		2400		6
7		C	PHARMACY	16		26537		7
8		C	OPERATION OF PLANT	8		12366		8
9	TO RECLASS INSURANCE EXPENSE	D	INSURANCE AND MALPRACTICE	94.01		144419		9
10		D	NURSING FACILITY	35		24005		10
11		D	HOME HEALTH AGENCY	71		10882		11
12	TO RECLASS SALARIES & OTHER EXP	E	CASHIERING/ACCOUNTS RECEIVABL	6.05	58481	55441		12
13	TO RECLASS SUPPLIES SOLD TO PATIE	F	CENTRAL SERVICES & SUPPLY	15		15004		13
14		F	EMERGENCY	61		6221		14
15		F	ANESTHESIOLOGY	40		8293		15
16		F	OPERATING ROOM	37		82683		16
17		F	RESPIRATORY THERAPY	49		1397		17
18		F	RURAL HEALTH CLINIC	63.50		24		18
19	TO RECLASS DRUGS TO PHARMACY	G	PHARMACY	16		352189		19
20	TO RECLASS SUPPLIES SOLD	H	SUPPLIES AND EXPENSE	94.02		7484		20
21	TO RECLASS NURSING CENTER PHONES	I	NONPATIENT TELEPHONES	6.01		4226		21
22	TO RECLASS NURSING CENTER DEPRECI	J	NEW CAP REL COSTS-BLDG & FIXT	3		30384	9	22
23		J	NEW CAP REL COSTS-MVBLE EQUIP	4		16670	9	23
24	TO RECLASS IV COSTS	K	PHARMACY	16		15386		24
25	TO RECLASS AUDIT COST	L	NURSING FACILITY	35		2887		25
26		L	HOME HEALTH AGENCY	71		2887		26
27	TO RECLASS HHA DEPRECIATION	M	NEW CAP REL COSTS-MVBLE EQUIP	4		14795	9	27
28	TO RECLASS MALPRACTICE INSURANCE	N	RURAL HEALTH CLINIC	63.50		28463		28
29	TO RECLASS ER TIME FOR RHC PHYS	O	RURAL HEALTH CLINIC	63.50	73810			29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				134163	960350		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	59449	15000		15000		74449		1
2	LAND IMPROVEMENTS	185578	414451		414451		600029		2
3	BUILDINGS AND FIXTURES	5191560	211495		211495	137723	5265332		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	4651814	317679		317679	32309	4937184		6
7	SUBTOTAL	10088401	958625		958625	170032	10876994		7
8	RECONCILING ITEMS								8
9	TOTAL	10088401	958625		958625	170032	10876994		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	5865358		5865358	.542961	13628			13628	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4937184		4937184	.457039	11471			11471	4
5	TOTAL	10802542		10802542	1.000000	25099			25099	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	176485			13628			190113	3
4	NEW CAP REL COSTS-MVBLE EQUIP	421713	98269		11471			531453	4
5	TOTAL	598198	98269		25099			721566	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	239147						239147	3
4	NEW CAP REL COSTS-MVBLE EQUIP	453178						453178	4
5	TOTAL	692325						692325	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	B	-28635	NEW CAP REL COSTS-BLDG & FIXT	3	11	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	B	-242	PURCHASING RECEIVING AND STORES	6.03		6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10	TELEVISION AND RADIO SERVICE	A	-1182	OTHER ADMINISTRATIVE AND GENERA	6.06		10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-191632				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						16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS	B	-15413	OTHER ADMINISTRATIVE AND GENERA	6.06		17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-12672	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-40615	DRUGS CHARGED TO PATIENTS	56		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4059	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	B	-1898	OTHER ADMINISTRATIVE AND GENERA	6.06		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	A	-32278	NEW CAP REL COSTS-BLDG & FIXT	3	9	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	COMMUNITY PROGRAM	B	-2587	OTHER ADMINISTRATIVE AND GENERA	6.06		37
38	HH COMMUNITY PROGRAM	B	-524	HOME HEALTH AGENCY	71		38
39	PORTION OF LOBBYING DUES	A	-4342	OTHER ADMINISTRATIVE AND GENERA	6.06		39
40	WOMENS WELLNESS	B	-58834	OTHER ADMINISTRATIVE AND GENERA	6.06		40
41	PHYSICIAN RECRUITMENT	A	-31346	OTHER ADMINISTRATIVE AND GENERA	6.06		41
42	ADVERTISING	A	-40963	OTHER ADMINISTRATIVE AND GENERA	6.06		42
43	IDPA ASSESSMENTS	A	33350	OTHER ADMINISTRATIVE AND GENERA	6.06		43
44	BEAUTY SHOP	A	-7753	NURSING FACILITY	35		44
45							45
46	FUNDRAISING	A	-4420	OTHER ADMINISTRATIVE AND GENERA	6.06		46
47	NH DIETARY	B	-1042	NURSING FACILITY	35		47
48	HH ADVERTISING	A	-168	HOME HEALTH AGENCY	71		48
49	NH SUPPLY TO OTHERS	B	-335	NURSING FACILITY	35		49
49.02	SURETY BOND	A	-100	NURSING FACILITY	35		49.02
49.03	FUND/MKT SALARIES	A	-38112	OTHER ADMINISTRATIVE AND GENERA	6.06		49.03
49.04	FUND/MKT BENEFITS	A	-8385	EMPLOYEE BENEFITS	5		49.04
49.06	FUNDRAISING	A	-149742	OTHER ADMINISTRATIVE AND GENERA	6.06		49.06
49.07	RHC ER SALARIES	A	-25833	EMERGENCY	61		49.07
49.08	RHC ER BENEFITS	A	-5683	EMPLOYEE BENEFITS	5		49.08
49.09	NON RHC COST	A	-101819	RURAL HEALTH CLINIC	63.50		49.09
49.10	NON RHC BENEFITS	A	-22400	EMPLOYEE BENEFITS	5		49.10
50	TOTAL		-799664				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
2	61	EMERGENCY	AGGREGATE	547520	191632	355888				
101		TOTAL		547520	191632	355888				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
2 61	EMERGENCY	AGGREGATE							191632
101	TOTAL								191632

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	202	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	4.40	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		1154.75				9
10	AHSEA		62.02				10
11	STANDARD TRAVEL ALLOWANCE	31.01	31.01				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	71618	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	71618	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	71618	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	71618	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	6264	24
25	ASSISTANTS		25
26	SUBTOTAL	6264	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	6264	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	6264	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	71618	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	6264	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	77882	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	57793	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	45706	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	12087	66.31
67	TOTAL COST	57793	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.790857	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.209143	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES 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	234	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS	75	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	4.40	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		421.25				9
10	AHSEA		65.45				10
11	STANDARD TRAVEL ALLOWANCE	32.73	32.73				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	27571	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	27571	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	27571	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	65.45	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	51051	22
23	TOTAL SALARY EQUIVALENCY	51051	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	7659	24
25	ASSISTANTS		25
26	SUBTOTAL	7659	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	7659	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	7659	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	2455	36
37	ASSISTANTS		37
38	SUBTOTAL	2455	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	2455	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	51051	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	7659	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	2455	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	61165	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	26497	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	23490	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	3007	66.31
67	TOTAL COST	26497	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.886515	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.113485	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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

[ ] OCCUPATIONAL [ ] PHYSICAL [ ] RESPIRATORY [XX] 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	146	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS	4	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	4.40	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		260.00				9
10	AHSEA		59.60				10
11	STANDARD TRAVEL ALLOWANCE	29.80	29.80				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	15496	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	15496	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	15496	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	59.60	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	46488	22
23	TOTAL SALARY EQUIVALENCY	46488	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 [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4351	24
25	ASSISTANTS		25
26	SUBTOTAL	4351	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4351	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	4351	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	119	36
37	ASSISTANTS		37
38	SUBTOTAL	119	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	119	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 [ ] PHYSICAL [ ] RESPIRATORY [XX] 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	46488	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	4351	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	119	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	50958	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	14559	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 [ ] PHYSICAL [ ] RESPIRATORY [XX] SPEECH PATHOLOGY

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	12173	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	2386	66.31
67	TOTAL COST	14559	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.836115	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.163885	68.31
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	NONPATIENT TELEPHONES 6.01	DATA PROCESSING 6.02	PURCHASING, RECEIVING AND STORAG 6.03	ADMITTING 6.04	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	190113	190113							3
4	NEW CAP REL COSTS-MVBLE EQUIP	531453		531453						4
5	EMPLOYEE BENEFITS	1477879			1477879					5
6.01	NONPATIENT TELEPHONES	23950	168	468		24586				6.01
6.02	DATA PROCESSING	83384	536	1499	14070	296	99785			6.02
6.03	PURCHASING RECEIVING AND STORES	43110	7050	19708	9354	592		79814		6.03
6.04	ADMITTING	113922	168	468	13852				128410	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	248543	972	2717	27746	889	80950			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	639990	27622	77215	80091	4150	18835	1696		6.06
8	OPERATION OF PLANT	432958	23416	65458	33548	592		1909		8
9	LAUNDRY & LINEN SERVICE	111701	4005	11195	17012	296		163		9
10	HOUSEKEEPING	121935			23653			1042		10
11	DIETARY	80158	3062	8560	3069	592		100		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION	251418	3791	10597	57404	1185		54		14
15	CENTRAL SERVICES & SUPPLY	7379	1148	3209				946		15
16	PHARMACY	212747	2874	8033	41038	296		23826		16
17	MEDICAL RECORDS & LIBRARY	168391	4084	11417	33214	1185		1020		17
18	SOCIAL SERVICE	42189	804	2248	8821	296		112		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1303328	45509	127226	288084	1185		5147	36668	25
35	NURSING FACILITY	1557280			301115	3258		4305		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	165972	12278	34322	32703	1185		6531	3017	37
40	ANESTHESIOLOGY	258996	641	1792	54272			1374	1245	40
41	RADIOLOGY-DIAGNOSTIC	505056	9463	26453	67605	889		1484	14696	41
44	LABORATORY	750500	6384	17846	76668	592		21567	18515	44
49	RESPIRATORY THERAPY	149516	3003	8396	30483	592		975	17222	49
50	PHYSICAL THERAPY	359394	5563	15551	62345	592		787	3921	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	3648						55	1628	53
55	MEDICAL SUPPLIES CHARGED TO PAT	100950							814	55
56	DRUGS CHARGED TO PATIENTS	326960							28615	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	634085	5676	15867	49657	592		4575	351	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	485017	18398	51430	97803	2666		1813	1718	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY	313764			54272	1185		333		71
	SPECIAL PURPOSE COST CENTERS									
94	OTHER SPECIAL PURPOSE COST CENT									94
94.01	INSURANCE AND MALPRACTICE									94.01
94.02	SUPPLIES AND EXPENSE									94.02
95	SUBTOTALS	11695686	186615	521675	1477879	23105	99785	79814	128410	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	68189	3498	9778		1481				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	11763875	190113	531453	1477879	24586	99785	79814	128410	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	CASHIERING /ACCOUNTS RECEIVABLE 6.05	SUBTOTAL 5A	OTHER ADMI NISTRATIVE AND GENER 6.06	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	NURSING ADMINIS-TRATION 14	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6.01	NONPATIENT TELEPHONES									6.01
6.02	DATA PROCESSING									6.02
6.03	PURCHASING RECEIVING AND STORES									6.03
6.04	ADMITTING									6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	361817								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		849599	849599						6.06
8	OPERATION OF PLANT		557881	43427	601308					8
9	LAUNDRY & LINEN SERVICE		144372	11238	18497	174107				9
10	HOUSEKEEPING		146630	11414		3003	161047			10
11	DIETARY		95541	7437	14144	759	24208	142089		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		324449	25256	17510		1167		368382	14
15	CENTRAL SERVICES & SUPPLY		12682	987	5301					15
16	PHARMACY		288814	22482	13273					16
17	MEDICAL RECORDS & LIBRARY		219311	17072	18865					17
18	SOCIAL SERVICE		54470	4240	3715					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	44884	1852031	144168	210219	21385	73548	142089	320476	25
35	NURSING FACILITY		1865958	145253		138920				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	14207	270215	21034	56710	977	6708		20239	37
40	ANESTHESIOLOGY	6796	325116	25308	2960					40
41	RADIOLOGY-DIAGNOSTIC	69046	694692	54077	43708	1576	4375			41
44	LABORATORY	85071	977143	76064	29487		10208			44
49	RESPIRATORY THERAPY	19782	229969	17901	13873					49
50	PHYSICAL THERAPY	20162	468315	36455	25695	4457	8750			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	7490	12821	998						53
55	MEDICAL SUPPLIES CHARGED TO PAT	6588	108352	8434						55
56	DRUGS CHARGED TO PATIENTS	46282	401857	31282						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	31425	742228	57777	26217	3030	20416		27667	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	10084	668929	52071	84978		11667			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY		369554	28767						71
	SPECIAL PURPOSE COST CENTERS									
94	OTHER SPECIAL PURPOSE COST CENT									94
94.01	INSURANCE AND MALPRACTICE									94.01
94.02	SUPPLIES AND EXPENSE									94.02
95	SUBTOTALS	361817	11680929	843142	585152	174107	161047	142089	368382	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		82946	6457	16156					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	361817	11763875	849599	601308	174107	161047	142089	368382	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	18	25	26	27	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	EMPLOYEE BENEFITS								5
6.01	NONPATIENT TELEPHONES								6.01
6.02	DATA PROCESSING								6.02
6.03	PURCHASING RECEIVING AND STORES								6.03
6.04	ADMITTING								6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA								6.06
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE								9
10	HOUSEKEEPING								10
11	DIETARY								11
12	CAFETERIA								12
14	NURSING ADMINISTRATION								14
15	CENTRAL SERVICES & SUPPLY	18970							15
16	PHARMACY		324569						16
17	MEDICAL RECORDS & LIBRARY			255248					17
18	SOCIAL SERVICE				62425				18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS			133357	19019	2916292		2916292	25
35	NURSING FACILITY					2150131		2150131	35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM					375883		375883	37
40	ANESTHESIOLOGY					353384		353384	40
41	RADIOLOGY-DIAGNOSTIC			59784		858212		858212	41
44	LABORATORY			22103		1115005		1115005	44
49	RESPIRATORY THERAPY					261743		261743	49
50	PHYSICAL THERAPY				7160	550832		550832	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY					13819		13819	53
55	MEDICAL SUPPLIES CHARGED TO PAT	18970				135756		135756	55
56	DRUGS CHARGED TO PATIENTS		320679			753818		753818	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY			40004	19018	936357		936357	61
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RURAL HEALTH CLINIC		3890		12082	833617		833617	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY				5146	403467		403467	71
	SPECIAL PURPOSE COST CENTERS								
94	OTHER SPECIAL PURPOSE COST CENT								94
94.01	INSURANCE AND MALPRACTICE								94.01
94.02	SUPPLIES AND EXPENSE								94.02
95	SUBTOTALS	18970	324569	255248	62425	11658316		11658316	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES					105559		105559	98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	18970	324569	255248	62425	11763875		11763875	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS	NEW CAP BLDGS & FIXTURES	NEW CAP MOVABLE EQUIPMENT	CAP REL COST TO BE ALLOC	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, RECEIVING AND STOR	ADMITTING	
		0	3	4	4A	6.01	6.02	6.03	6.04	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6.01	NONPATIENT TELEPHONES		168	468	636	636				6.01
6.02	DATA PROCESSING		536	1499	2035	8	2043			6.02
6.03	PURCHASING RECEIVING AND STORES		7050	19708	26758	15		26773		6.03
6.04	ADMITTING		168	468	636				636	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE		972	2717	3689	23	1657			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		27622	77215	104837	107	386	569		6.06
8	OPERATION OF PLANT		23416	65458	88874	15		640		8
9	LAUNDRY & LINEN SERVICE		4005	11195	15200	8		55		9
10	HOUSEKEEPING							350		10
11	DIETARY		3062	8560	11622	15		33		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		3791	10597	14388	31		18		14
15	CENTRAL SERVICES & SUPPLY		1148	3209	4357			317		15
16	PHARMACY		2874	8033	10907	8		7991		16
17	MEDICAL RECORDS & LIBRARY		4084	11417	15501	31		342		17
18	SOCIAL SERVICE		804	2248	3052	8		37		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		45509	127226	172735	31		1727	183	25
35	NURSING FACILITY					84		1444		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		12278	34322	46600	31		2191	15	37
40	ANESTHESIOLOGY		641	1792	2433			461	6	40
41	RADIOLOGY-DIAGNOSTIC		9463	26453	35916	23		498	73	41
44	LABORATORY		6384	17846	24230	15		7235	92	44
49	RESPIRATORY THERAPY		3003	8396	11399	15		327	85	49
50	PHYSICAL THERAPY		5563	15551	21114	15		264	19	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY							19	8	53
55	MEDICAL SUPPLIES CHARGED TO PAT								4	55
56	DRUGS CHARGED TO PATIENTS								141	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		5676	15867	21543	15		1535	2	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC		18398	51430	69828	69		608	8	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY					31		112		71
	SPECIAL PURPOSE COST CENTERS									
94	OTHER SPECIAL PURPOSE COST CENT									94
94.01	INSURANCE AND MALPRACTICE									94.01
94.02	SUPPLIES AND EXPENSE									94.02
95	SUBTOTALS		186615	521675	708290	598	2043	26773	636	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		3498	9778	13276	38				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		190113	531453	721566	636	2043	26773	636	103

ALLOCATION OF NEW CAPITAL RELATED COSTS — WORKSHEET B PART III

	COST CENTER DESCRIPTION	CASHIERING /ACCOUNTS RECEIVABLE 6.05	OTHER ADMI NISTRATIVE AND GENER 6.06	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	NURSING ADMINIS-TRATION 14	CENTRAL SERVICES & SUPPLY 15	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6.01	NONPATIENT TELEPHONES									6.01
6.02	DATA PROCESSING									6.02
6.03	PURCHASING RECEIVING AND STORES									6.03
6.04	ADMITTING									6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	5369								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		105899							6.06
8	OPERATION OF PLANT		5413	94942						8
9	LAUNDRY & LINEN SERVICE		1401	2921	19585					9
10	HOUSEKEEPING		1423		338	2111				10
11	DIETARY		927	2233	85	317	15232			11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		3148	2765		15		20365		14
15	CENTRAL SERVICES & SUPPLY		123	837					5634	15
16	PHARMACY		2802	2096						16
17	MEDICAL RECORDS & LIBRARY		2128	2979						17
18	SOCIAL SERVICE		529	587						18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	666	17970	33192	2406	964	15232	17717		25
35	NURSING FACILITY		18103		15627					35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	211	2622	8954	110	88		1119		37
40	ANESTHESIOLOGY	101	3155	467						40
41	RADIOLOGY-DIAGNOSTIC	1025	6741	6901	177	57				41
44	LABORATORY	1260	9481	4656		134				44
49	RESPIRATORY THERAPY	294	2231	2190						49
50	PHYSICAL THERAPY	299	4544	4057	501	115				50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	111	124							53
55	MEDICAL SUPPLIES CHARGED TO PAT	98	1051						5634	55
56	DRUGS CHARGED TO PATIENTS	687	3899							56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	467	7202	4139	341	268		1529		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	150	6491	13417		153				63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY		3586							71
	SPECIAL PURPOSE COST CENTERS									
94	OTHER SPECIAL PURPOSE COST CENT									94
94.01	INSURANCE AND MALPRACTICE									94.01
94.02	SUPPLIES AND EXPENSE									94.02
95	SUBTOTALS	5369	105094	92391	19585	2111	15232	20365	5634	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		805	2551						98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	5369	105899	94942	19585	2111	15232	20365	5634	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B
PART III

	COST CENTER DESCRIPTION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	18	25	26	27	
	GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT							3
4	NEW CAP REL COSTS-MVBLE EQUIP							4
5	EMPLOYEE BENEFITS							5
6.01	NONPATIENT TELEPHONES							6.01
6.02	DATA PROCESSING							6.02
6.03	PURCHASING RECEIVING AND STORES							6.03
6.04	ADMITTING							6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE							6.05
6.06	OTHER ADMINISTRATIVE AND GENERA							6.06
8	OPERATION OF PLANT							8
9	LAUNDRY & LINEN SERVICE							9
10	HOUSEKEEPING							10
11	DIETARY							11
12	CAFETERIA							12
14	NURSING ADMINISTRATION							14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY	23804						16
17	MEDICAL RECORDS & LIBRARY		20981					17
18	SOCIAL SERVICE			4213				18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS		10962	1284	275069		275069	25
35	NURSING FACILITY				35258		35258	35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM				61941		61941	37
40	ANESTHESIOLOGY				6623		6623	40
41	RADIOLOGY-DIAGNOSTIC		4914		56325		56325	41
44	LABORATORY		1817		48920		48920	44
49	RESPIRATORY THERAPY				16541		16541	49
50	PHYSICAL THERAPY			483	31411		31411	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY				262		262	53
55	MEDICAL SUPPLIES CHARGED TO PAT				6787		6787	55
56	DRUGS CHARGED TO PATIENTS	23519			28246		28246	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY		3288	1284	41613		41613	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	285		815	91824		91824	63.50
	OTHER REIMBURSABLE COST CENTERS							
71	HOME HEALTH AGENCY			347	4076		4076	71
	SPECIAL PURPOSE COST CENTERS							
94	OTHER SPECIAL PURPOSE COST CENT							94
94.01	INSURANCE AND MALPRACTICE							94.01
94.02	SUPPLIES AND EXPENSE							94.02
95	SUBTOTALS	23804	20981	4213	704896		704896	95
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES				16670		16670	98
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	23804	20981	4213	721566		721566	103

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	NONPATIENT TELEPHONES #OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING, RECEIVING AND STOR COSTS SUPPLIES	ADMITTING INPATIENT CHARGES	
		3	4	5	6.01	6.02	6.03	6.04	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	45385							3
4	NEW CAP REL COSTS-MVBLE EQUIP		45385						4
5	EMPLOYEE BENEFITS			6239314					5
6.01	NONPATIENT TELEPHONES	40	40		83				6.01
6.02	DATA PROCESSING	128	128	59401	1	249			6.02
6.03	PURCHASING RECEIVING AND STOR	1683	1683	39491	2		1266485		6.03
6.04	ADMITTING	40	40	58481				5719577	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABL	232	232	117138	3	202			6.05
6.06	OTHER ADMINISTRATIVE AND GENE	6594	6594	338129	14	47	26914		6.06
8	OPERATION OF PLANT	5590	5590	141632	2		30290		8
9	LAUNDRY & LINEN SERVICE	956	956	71823	1		2581		9
10	HOUSEKEEPING			99857			16535		10
11	DIETARY	731	731	12958	2		1581		11
12	CAFETERIA								12
14	NURSING ADMINISTRATION	905	905	242346	4		857		14
15	CENTRAL SERVICES & SUPPLY	274	274				15004		15
16	PHARMACY	686	686	173254	1		378120		16
17	MEDICAL RECORDS & LIBRARY	975	975	140222	4		16179		17
18	SOCIAL SERVICE	192	192	37239	1		1770		18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	10865	10865	1216231	4		81677	1633324	25
35	NURSING FACILITY			1271252	11		68319		35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	2931	2931	138067	4		103626	134386	37
40	ANESTHESIOLOGY	153	153	229127			21796	55436	40
41	RADIOLOGY-DIAGNOSTIC	2259	2259	285416	3		23545	654570	41
44	LABORATORY	1524	1524	323676	2		342219	824682	44
49	RESPIRATORY THERAPY	717	717	128695	2		15470	767092	49
50	PHYSICAL THERAPY	1328	1328	263209	2		12482	174655	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY						879	72509	53
55	MEDICAL SUPPLIES CHARGED TO P							36244	55
56	DRUGS CHARGED TO PATIENTS							1274552	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	1355	1355	209640	2		72589	15622	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC	4392	4392	412905	9		28762	76505	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY			229125	4		5290		71
	SPECIAL PURPOSE COST CENTERS								
94	OTHER SPECIAL PURPOSE COST CE								94
94.01	INSURANCE AND MALPRACTICE								94.01
94.02	SUPPLIES AND EXPENSE								94.02
95	SUBTOTALS	44550	44550	6239314	78	249	1266485	5719577	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES	835	835		5				98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	190113	531453	1477879	24586	99785	79814	128410	103
104	UNIT COST MULT-WS B PT I		11.709882		296.216867		.063020		104
104	UNIT COST MULT-WS B PT I	4.188895		.236866		400.742972		.022451	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				636	2043	26773	636	107
108	UNIT COST MULT-WS B PT III				7.662651		.021140		108
108	UNIT COST MULT-WS B PT III					8.204819		.000111	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	NURSING ADMINIS-TRATION HOURS OF SERVICE	
		6.05	6A.06	6.06	8	9	10	11	14	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6.01	NONPATIENT TELEPHONES									6.01
6.02	DATA PROCESSING									6.02
6.03	PURCHASING RECEIVING AND STOR									6.03
6.04	ADMITTING									6.04
6.05	CASHIERING/ACCOUNTS RECEIVABL	18589370								6.05
6.06	OTHER ADMINISTRATIVE AND GENE		-849599	10914276						6.06
8	OPERATION OF PLANT			557881	31078					8
9	LAUNDRY & LINEN SERVICE			144372	956	796867				9
10	HOUSEKEEPING			146630		13745	6626			10
11	DIETARY			95541	731	3475	996	13164		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION			324449	905		48		94030	14
15	CENTRAL SERVICES & SUPPLY			12682	274					15
16	PHARMACY			288814	686					16
17	MEDICAL RECORDS & LIBRARY			219311	975					17
18	SOCIAL SERVICE			54470	192					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	2306013		1852031	10865	97876	3026	13164	81802	25
35	NURSING FACILITY			1865958		635819				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	729896		270215	2931	4470	276		5166	37
40	ANESTHESIOLOGY	349181		325116	153					40
41	RADIOLOGY-DIAGNOSTIC	3547373		694692	2259	7212	180			41
44	LABORATORY	4370999		977143	1524		420			44
49	RESPIRATORY THERAPY	1016342		229969	717					49
50	PHYSICAL THERAPY	1035870		468315	1328	20401	360			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	384827		12821						53
55	MEDICAL SUPPLIES CHARGED TO P	338457		108352						55
56	DRUGS CHARGED TO PATIENTS	2377824		401857						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1614518		742228	1355	13869	840		7062	61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RURAL HEALTH CLINIC	518070		668929	4392		480			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY			369554						71
	SPECIAL PURPOSE COST CENTERS									
94	OTHER SPECIAL PURPOSE COST CE									94
94.01	INSURANCE AND MALPRACTICE									94.01
94.02	SUPPLIES AND EXPENSE									94.02
95	SUBTOTALS	18589370	-849599	10831330	30243	796867	6626	13164	94030	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES			82946	835					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	361817		849599	601308	174107	161047	142089	368382	103
104	UNIT COST MULT-WS B PT I	.019464		.077843		.218489		10.793756		104
104	UNIT COST MULT-WS B PT I				19.348349		24.305312		3.917707	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	5369		105899	94942	19585	2111	15232	20365	107
108	UNIT COST MULT-WS B PT III	.000289		.009703		.024578		1.157095		108
108	UNIT COST MULT-WS B PT III				3.054958		.318593		.216580	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO 15	PHARMACY COSTED REQUISITIO 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
	GENERAL SERVICE COST CENTERS					
3	NEW CAP REL COSTS-BLDG & FIXT					3
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6.01	NONPATIENT TELEPHONES					6.01
6.02	DATA PROCESSING					6.02
6.03	PURCHASING RECEIVING AND STOR					6.03
6.04	ADMITTING					6.04
6.05	CASHIERING/ACCOUNTS RECEIVABL					6.05
6.06	OTHER ADMINISTRATIVE AND GENE					6.06
8	OPERATION OF PLANT					8
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY	113623				15
16	PHARMACY		373798			16
17	MEDICAL RECORDS & LIBRARY			54739		17
18	SOCIAL SERVICE				8370	18
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS			28599	2550	25
35	NURSING FACILITY					35
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM					37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC			12821		41
44	LABORATORY			4740		44
49	RESPIRATORY THERAPY					49
50	PHYSICAL THERAPY				960	50
51	OCCUPATIONAL THERAPY					51
52	SPEECH PATHOLOGY					52
53	ELECTROCARDIOLOGY					53
55	MEDICAL SUPPLIES CHARGED TO P	113623				55
56	DRUGS CHARGED TO PATIENTS		369318			56
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY			8579	2550	61
62	OBSERVATION BEDS (NON-DISTINC					62
63.50	RURAL HEALTH CLINIC		4480		1620	63.50
	OTHER REIMBURSABLE COST CENTERS					
71	HOME HEALTH AGENCY				690	71
	SPECIAL PURPOSE COST CENTERS					
94	OTHER SPECIAL PURPOSE COST CE					94
94.01	INSURANCE AND MALPRACTICE					94.01
94.02	SUPPLIES AND EXPENSE					94.02
95	SUBTOTALS	113623	373798	54739	8370	95
	NONREIMBURSABLE COST CENTERS					
98	PHYSICIANS' PRIVATE OFFICES					98
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	COST TO BE ALLOC PER B PT I	18970	324569	255248	62425	103
104	UNIT COST MULT-WS B PT I	.166956		4.663001		104
104	UNIT COST MULT-WS B PT I		.868301		7.458184	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	5634	23804	20981	4213	107
108	UNIT COST MULT-WS B PT III	.049585		.383292		108
108	UNIT COST MULT-WS B PT III		.063681		.503345	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	2916292		2916292		2916292	25
35	NURSING FACILITY	2150131		2150131		2150131	35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	375883		375883		375883	37
40	ANESTHESIOLOGY	353384		353384		353384	40
41	RADIOLOGY-DIAGNOSTIC	858212		858212		858212	41
44	LABORATORY	1115005		1115005		1115005	44
49	RESPIRATORY THERAPY	261743		261743		261743	49
50	PHYSICAL THERAPY	550832		550832		550832	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	13819		13819		13819	53
55	MEDICAL SUPPLIES CHARGED TO	135756		135756		135756	55
56	DRUGS CHARGED TO PATIENTS	753818		753818		753818	56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	936357		936357		936357	61
62	OBSERVATION BEDS (NON-DISTI	565560		565560		565560	62
63.50	RURAL HEALTH CLINIC	833617		833617		833617	63.50
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	11820409		11820409		11820409	101
102	LESS OBSERVATION BEDS	565560		565560		565560	102
103	TOTAL	11254849		11254849		11254849	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	1633324		1633324				25
35	NURSING FACILITY	1759964		1759964				35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	41748	372534	414282	.907312	.907312	.907312	37
40	ANESTHESIOLOGY	54727	291005	345732	1.022133	1.022133	1.022133	40
41	RADIOLOGY-DIAGNOSTIC	636740	2830278	3467018	.247536	.247536	.247536	41
44	LABORATORY	824682	3546317	4370999	.255092	.255092	.255092	44
49	RESPIRATORY THERAPY	383118	105402	488520	.535788	.535788	.535788	49
50	PHYSICAL THERAPY	177060	855715	1032775	.533351	.533351	.533351	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	94509	290318	384827	.035910	.035910	.035910	53
55	MEDICAL SUPPLIES CHARGED TO	574899	700962	1275861	.106403	.106403	.106403	55
56	DRUGS CHARGED TO PATIENTS	1274552	1103272	2377824	.317020	.317020	.317020	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	12813	1601546	1614359	.580018	.580018	.580018	61
62	OBSERVATION BEDS (NON-DISTI	1000	610106	611106	.925470	.925470	.925470	62
63.50	RURAL HEALTH CLINIC	76505	441565	518070	1.609082	1.609082	1.609082	63.50
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	7545641	12749020	20294661				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	7545641	12749020	20294661				103

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

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	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	.907312	.907312	.907312				37
40	ANESTHESIOLOGY	1.022133	1.022133	1.022133				40
41	RADIOLOGY-DIAGNOSTIC	.247536	.247536	.247536				41
44	LABORATORY	.255092	.255092	.255092				44
49	RESPIRATORY THERAPY	.535788	.535788	.535788				49
50	PHYSICAL THERAPY	.533351	.533351	.533351				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.035910	.035910	.035910				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.106403	.106403	.106403				55
56	DRUGS CHARGED TO PATIENTS	.317020	.317020	.317020				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.580018	.580018	.580018				61
62	OBSERVATION BEDS (NON-DISTINCT	.925470	.925470	.925470				62
63.50	RURAL HEALTH CLINIC	1.609082	1.609082	1.609082				63.50
	OTHER REIMBURSABLE COST CENTERS							
65.01	AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03	AMBULANCE SERVICES (4TH PERIOD)							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	.317020	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 APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	SNF	
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF	
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF	
			[ ]	SUB III	[ ]	S/B-NF	
			[ ]	SUB IV	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST OUTPATIENT RADIOLOGY 7	PROGRAM COST OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	155865								37
40	ANESTHESIOLOGY	63215								40
41	RADIOLOGY-DIAGNOSTIC	886269								41
44	LABORATORY	1433483								44
49	RESPIRATORY THERAPY	85265								49
50	PHYSICAL THERAPY	238642								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	183098								53
55	MEDICAL SUPPLIES CHARGED TO PA	251412								55
56	DRUGS CHARGED TO PATIENTS	484581								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	559600								61
62	OBSERVATION BEDS (NON-DISTINCT	268636								62
63.50	RURAL HEALTH CLINIC									63.50
	OTHER REIMBURSABLE COST CENTERS									
65.01	AMBULANCE SERVICES (2ND PERIOD									65.01
65.02	AMBULANCE SERVICES (3RD PERIOD									65.02
65.03	AMBULANCE SERVICES (4TH PERIOD									65.03
101	SUBTOTAL	4610066								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	4610066								104

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	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 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	PROGRAM COST 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	141418							37
40	ANESTHESIOLOGY	64614							40
41	RADIOLOGY-DIAGNOSTIC	219383							41
44	LABORATORY	365670							44
49	RESPIRATORY THERAPY	45684							49
50	PHYSICAL THERAPY	127280							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	6575							53
55	MEDICAL SUPPLIES CHARGED TO PAT	26751							55
56	DRUGS CHARGED TO PATIENTS	153622							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	324578							61
62	OBSERVATION BEDS (NON-DISTINCT	248615							62
63.50	RURAL HEALTH CLINIC								63.50
	OTHER REIMBURSABLE COST CENTERS								
65.01	AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03	AMBULANCE SERVICES (4TH PERIOD)								65.03
101	SUBTOTAL	1724190							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1724190							104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS WORKSHEET D
PART I

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

	COST CENTER DESCRIPTION	OLD CAPITAL: CAPITAL RELATED COST (1)	OLD CAPITAL: SWING-BED ADJUSTMENT (2)	OLD CAPITAL: REDUCED CAPITAL RELATED COST (3)	NEW CAPITAL: CAPITAL RELATED COST (4)	NEW CAPITAL: SWING-BED ADJUSTMENT (5)	NEW CAPITAL: REDUCED CAPITAL RELATED COST (6)	
	INPAT ROUTINE SERV COST CTRS							
25	ADULTS & PEDIATRICS				275069	40988	234081	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				275069		234081	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	3980	291			58.81	17114	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	3980	291				17114	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS — WORKSHEET D PART II

CHECK APPLICABLE BOXES	[ ] TITLE V	[XX] HOSPITAL (14-1326)	[ ] SUB III	[XX] PPS
	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SUB IV	[ ] TEFRA
	[XX] TITLE XIX	[ ] SUB II	[ ] OTHER	

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	---- OLD CAPITAL ---- RATIO OF COST TO CHARGES 5	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		61941	414282	14911			.149514	2229	37
40	ANESTHESIOLOGY		6623	345732	17919			.019156	343	40
41	RADIOLOGY-DIAGNOSTIC		56325	3467018	53244			.016246	865	41
44	LABORATORY		48920	4370999	84383			.011192	944	44
49	RESPIRATORY THERAPY		16541	488520	27145			.033859	919	49
50	PHYSICAL THERAPY		31411	1032775	2526			.030414	77	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		262	384827	16950			.000681	12	53
55	MEDICAL SUPPLIES CHARGED TO P		6787	1275861	118510			.005320	630	55
56	DRUGS CHARGED TO PATIENTS		28246	2377824	105022			.011879	1248	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		41613	1614359				.025777		61
62	OBSERVATION BEDS (NON-DISTINC			611106						62
63.50	RURAL HEALTH CLINIC			518070						63.50
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		298669	16383303	440610				7267	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					3980		291		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					3980		291		101

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

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1326)	[ ] 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	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
49	RESPIRATORY THERAPY							49
50	PHYSICAL THERAPY							50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY							53
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	RURAL HEALTH CLINIC							63.50
	OTHER REIMBURSABLE COST CENTERS							
101	TOTAL							101

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

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1326)	[ ] 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		414282			14911			37
40	ANESTHESIOLOGY		345732			17919			40
41	RADIOLOGY-DIAGNOSTIC		3467018			53244			41
44	LABORATORY		4370999			84383			44
49	RESPIRATORY THERAPY		488520			27145			49
50	PHYSICAL THERAPY		1032775			2526			50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY		384827			16950			53
55	MEDICAL SUPPLIES CHARGED TO P		1275861			118510			55
56	DRUGS CHARGED TO PATIENTS		2377824			105022			56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		1614359						61
62	OBSERVATION BEDS (NON-DISTINC		611106						62
63.50	RURAL HEALTH CLINIC		518070						63.50
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		16383303			440610			101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1326)	[ ]	SUB IV	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ] OTHER
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY						53
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	RURAL HEALTH CLINIC						63.50
	OTHER REIMBURSABLE COST CENTERS						
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) (14-1326) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4704						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3980						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3980						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	346						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	346						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	16						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2412						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	346						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	346						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) (14-1326)	SUB I	SUB II	SUB III	SUB IV	SNF	
	SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	94.55						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	96.45						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2916292						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	1513						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1543						25
26	TOTAL SWING-BED COST	434553						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2481739						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1424710						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1424710						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.741926						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	357.97						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	2481739						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) (14-1326)	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	623.55					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1504003					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1504003					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) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	811333					48
49	TOTAL PROGRAM INPATIENT COSTS	2315336					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

		HOSPITAL (OTHER) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
	TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	215748					60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	215748					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	431496					62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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

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

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

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

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

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

	HOSPITAL (OTHER) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	907					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	623.55					84
85 OBSERVATION BED COST	565560					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 (PPS) (14-1326)	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)	4704						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3980						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3980						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	346						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	346						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	16						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	16						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	291						9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

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

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

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (PPS) (14-1326)	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	94.55						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	96.45						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2916292						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	1513						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1543						25
26	TOTAL SWING-BED COST	434553						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2481739						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1424710						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1424710						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.741926						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	357.97						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	2481739						37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (PPS) (14-1326)	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	623.55					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	181453					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	181453					41

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

		HOSPITAL (PPS) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	128954					48
49	TOTAL PROGRAM INPATIENT COSTS	310407					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	17114					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	7267					51
52	TOTAL PROGRAM EXCLUDABLE COST	24381					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	286026					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 (PPS) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

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

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

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

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

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

	HOSPITAL (PPS) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	907					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	623.55					84
85 OBSERVATION BED COST	565560					85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL

	COST 1	ROUTINE COST (FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		2481739		565560		86
87 NEW CAPITAL-RELATED COST		2481739		565560		87
88 NON PHYSICIAN ANESTHETIST		2481739		565560		88
89 MEDICAL EDUCATION		2481739		565560		89

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ]	TITLE V	[XX]	HOSPITAL (14-1326)	[ ]	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		1198057		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.907312	15782	14319	37
40	ANESTHESIOLOGY	1.022133	14770	15097	40
41	RADIOLOGY-DIAGNOSTIC	.247536	376188	93120	41
44	LABORATORY	.255092	581634	148370	44
49	RESPIRATORY THERAPY	.535788	316880	169781	49
50	PHYSICAL THERAPY	.533351	95306	50832	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.035910	61953	2225	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.106403	367675	39122	55
56	DRUGS CHARGED TO PATIENTS	.317020	862297	273365	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.580018	8796	5102	61
62	OBSERVATION BEDS (NON-DISTINCT	.925470			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.609082			63.50
101	TOTAL		2701281	811333	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		2701281		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-Z326)	[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	.907312	2916	2646	37
40	ANESTHESIOLOGY	1.022133	1284	1312	40
41	RADIOLOGY-DIAGNOSTIC	.247536	34065	8432	41
44	LABORATORY	.255092	59368	15144	44
49	RESPIRATORY THERAPY	.535788	30945	16580	49
50	PHYSICAL THERAPY	.533351	62765	33476	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.035910	8687	312	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.106403	60469	6434	55
56	DRUGS CHARGED TO PATIENTS	.317020	177690	56331	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.580018			61
62	OBSERVATION BEDS (NON-DISTINCT	.925470			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.609082			63.50
101	TOTAL		438189	140667	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		438189		103

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1326)	[ ] SNF	[XX] PPS
[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[XX] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[ ] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		140855		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.907312	14911	13529	37
40	ANESTHESIOLOGY	1.022133	17919	18316	40
41	RADIOLOGY-DIAGNOSTIC	.247536	53244	13180	41
44	LABORATORY	.255092	84383	21525	44
49	RESPIRATORY THERAPY	.535788	27145	14544	49
50	PHYSICAL THERAPY	.533351	2526	1347	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.035910	16950	609	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.106403	118510	12610	55
56	DRUGS CHARGED TO PATIENTS	.317020	105022	33294	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.580018			61
62	OBSERVATION BEDS (NON-DISTINCT	.925470			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.609082			63.50
101	TOTAL		440610	128954	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		440610		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
3.17	SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO	RES. IN INIT YRS 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 [SUM OF LINES][PLUS E-3,PT.VI] [3.21-3.23][LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23	0		0			3.24
	DISPROPORTIONATE SHARE ADJUSTMENT						
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS						4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS						4.01
4.02	SUM OF 4 AND 4.01						4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT						4.04
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317						5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302,						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs						5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						5.05
5.06	TOTAL ADDITIONAL PAYMENT						5.06
6	SUBTOTAL						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 INSTRUCTIO						52
53	CAPITAL OUTLIER RECONILIATION AMOUNT (SEE INSTRUCTIONS)						53
54	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						54
55	TIME VALUE OF MONEY (SEE INSTRUCTIONS)						55
56	CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)						56

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1326) 1	HOSPITAL (14-1326) 1.01	HOSPITAL (14-1326) 1.02	
1	MEDICAL AND OTHER SERVICES	1724190			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	1724190			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	1741432			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1326) 1	HOSPITAL (14-1326) 1.01	HOSPITAL (14-1326) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	25184			18
18.01	COINSURANCE	635459			18.01
19	SUBTOTAL	1080789			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	1080789			23
24	PRIMARY PAYER PAYMENTS	3			24
25	SUBTOTAL	1080786			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	207030			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	207030			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	207030			27.02
28	SUBTOTAL	1287816			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	1287816			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1538185			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	-250369			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 (14-1326) OCTOBER 1, 1997 PRIOR TO ON OR AFTER 1 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 (14-1326) 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 (14-1326) 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 (14-1326)

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				1770035		1538185	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	.02					3.02
	TO	.03		NONE		NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				1770035		1538185	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		NONE		NONE	5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51		NONE		NONE	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		126608			6.01
	PROVIDER TO PROGRAM	.02				-250369	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				1896643		1287816	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-Z326)

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				560424			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	.02					3.02
	TO	.03		NONE		NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				560424			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		NONE		NONE	5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51		NONE		NONE	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		-4587			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				555837			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-Z326)	S/B SNF PART B (14-Z326)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		435811				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		142074				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		692				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		577885				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		577885				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		577885				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		22048				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		555837				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		555837				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		560424				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		-4587				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						22

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1326)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2315336						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	2315336						4
5	PRIMARY PAYER PAYMENTS	596						5
6	TOTAL COST	2337887						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 (14-1326)	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	2337887						19
20	DEDUCTIBLES	507605						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	1830282						22
23	COINSURANCE	2480						23
24	SUBTOTAL	1827802						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	68841						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	68841						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	68841						25.02
26	SUBTOTAL	1896643						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	OTHER ADJUSTMENTS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	1896643						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1770035						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	126608						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

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 (14-1326) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES							1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							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	440610						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							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							30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31							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 (14-1326) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST							34
35	SUBTOTAL							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							40
41	INPATIENT ROUTINE SERVICE COST							41
42	MEDICARE INPATIENT ROUTINE CHARGES							42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							44
45	RATIO OF LINE 43 TO LINE 44							45
46	TOTAL CUSTOMARY CHARGES							46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							49
50	OTHER ADJUSTMENTS							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL							52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER							55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM							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	2247908				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3360424				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-709000				6
7	INVENTORY	434725				7
8	PREPAID EXPENSES	702585				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	6036642				11
	FIXED ASSETS					
12	LAND	74449				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	2767612				13
13.01	ACCUMULATED DEPRECIATION	-205211				13.01
14	BUILDINGS	5298594				14
14.01	ACCUMULATED DEPRECIATION	-3251244				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	4903920				18
18.01	ACCUMULATED DEPRECIATION	-3209368				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	6378752				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	16702541		100758		25
26	TOTAL OTHER ASSETS	16702541		100758		26
27	TOTAL ASSETS	29117935		100758		27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	710123				28
29	SALARIES, WAGES & FEES PAYABLE	649470				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	148883				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	442842				35
36	TOTAL CURRENT LIABILITIES	1951318				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	19774059				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					41
42	TOTAL LONG TERM LIABILITIES	19774059				42
43	TOTAL LIABILITIES	21725377				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	7392558				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			100758		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	7392558		100758		51
52	TOTAL LIABILITIES AND FUND BALANCES	29117935		100758		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	6911755		103996		1
2	NET INCOME (LOSS)	480803				2
3	TOTAL	7392558		103996		3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	7392558		103996		11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)			3238		12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS			3238		18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	7392558		100758		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	1424710		1424710	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	108006		108006	4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	1532716		1532716	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	1532716		1532716	16
17	ANCILLARY SERVICES	4093509	10829332	14922841	17
18	OUTPATIENT SERVICES	54975	2509201	2564176	18
18.50	RURAL HEALTH CLINIC	76505	441565	518070	18.50
19	HOME HEALTH AGENCY		268780	268780	19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24	OTHER	1759964		1759964	24
25	TOTAL PATIENT REVENUES	7517669	14048878	21566547	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		12563539	26
27	BAD DEBTS	1377033		27
28	LOSS ON SWAP CONTRACT	932000		28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		2309033	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		14872572	40

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	21566547	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	8087855	2
3	NET PATIENT REVENUES	13478692	3
4	LESS - TOTAL OPERATING EXPENSES	14872572	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1393880	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1251513	6
7	INCOME FROM INVESTMENTS	64898	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	242	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS		14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	12672	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	40615	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS	399218	23
24	OTHER	105525	24
25	TOTAL OTHER INCOME	1874683	25
26	TOTAL	480803	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	480803	31

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7167 WORKSHEET H

		SALARIES	EMPLOYEE BENEFITS	TRANS-PORTATION	CONTRACTED/ PURCH SVCS	OTHER COSTS	TOTAL HHA COST	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDG & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION							4
5	ADMINISTRATIVE AND GENERAL	72988				41496	114484	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	108348				17659	126007	6
7	PHYSICAL THERAPY	47787			3007	4733	55527	7
8	OCCUPATIONAL THERAPY				12087		12087	8
9	SPEECH PATHOLOGY				2386		2386	9
10	MEDICAL SOCIAL SERVICES					250	250	10
11	HOME HEALTH AIDE	336					336	11
12	SUPPLIES					2687	2687	12
13	DRUGS							13
13.20	COST OF ADMINISTERING VACCINES							13.20
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL	229459			17480	66825	313764	24

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS HHA NO.: 14-7167 WORKSHEET H (CONTINUED)

		RECLASSIFI-CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDG & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION					4
5	ADMINISTRATIVE AND GENERAL		114484		114484	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		126007		126007	6
7	PHYSICAL THERAPY		55527		55527	7
8	OCCUPATIONAL THERAPY		12087		12087	8
9	SPEECH PATHOLOGY		2386		2386	9
10	MEDICAL SOCIAL SERVICES		250		250	10
11	HOME HEALTH AIDE		336		336	11
12	SUPPLIES		2687		2687	12
13	DRUGS					13
13.20	COST OF ADMINISTERING VACCINES					13.20
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL		313764		313764	24

COST ALLOCATION - HHA GENERAL SERVICE COST HHA NO.: 14-7167 WORKSHEET H-4 PART I

		NET EXPENSES FOR COST ALLOCATION 0	CAP REL BLDGS & FIXTURES 1	CAP REL MOVABLE EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT-ATION 4	SUBTOTAL 4A	ADMIN & GENERAL 5	TOTAL 6	
	GENERAL SERVICE COST CENTER									
1	CAPITAL RELATED-BLDG & FIXT									1
2	CAPITAL RELATED-MOVABLE EQUIP									2
3	PLANT OPERATION & MAINTENANCE									3
4	TRANSPORTATION									4
5	ADMINISTRATIVE AND GENERAL	114484					114484	114484		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	126007					126007	72388	198395	6
7	PHYSICAL THERAPY	55527					55527	31900	87427	7
8	OCCUPATIONAL THERAPY	12087					12087	6944	19031	8
9	SPEECH PATHOLOGY	2386					2386	1371	3757	9
10	MEDICAL SOCIAL SERVICES	250					250	144	394	10
11	HOME HEALTH AIDE	336					336	193	529	11
12	SUPPLIES	2687					2687	1544	4231	12
13	DRUGS									13
13.20	COST OF ADMINISTERING VACCINES									13.20
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	HOME DIALYSIS AIDE SERVICES									15
16	RESPIRATORY THERAPY									16
17	PRIVATE DUTY NURSING									17
18	CLINIC									18
19	HEALTH PROMOTION ACTIVITIES									19
20	DAY CARE PROGRAM									20
21	HOME DELIVERED MEALS PROGRAM									21
22	HOMEMAKER SERVICE									22
23	ALL OTHERS									23
23.50	TELEMEDICINE									23.50
24	TOTAL	313764					313764		313764	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7167

WORKSHEET H-4
PART II

		CAP REL BLDGS & FIXTURES (SQUARE FEET) 1	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDG & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION							4
5	ADMINISTRATIVE AND GENERAL					-114484	199280	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						126007	6
7	PHYSICAL THERAPY						55527	7
8	OCCUPATIONAL THERAPY						12087	8
9	SPEECH PATHOLOGY						2386	9
10	MEDICAL SOCIAL SERVICES						250	10
11	HOME HEALTH AIDE						336	11
12	SUPPLIES						2687	12
13	DRUGS							13
13.20	COST OF ADMINISTERING VACCINES							13.20
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL					-114484	199280	24
25	COST TO BE ALLOC (PER W/S H)						114484	25
26	UNIT COST MULTIPLIER						.574488	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
PART I

	HHA COST CENTER	HHA TRIAL BALANCE 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	NONPATIENT TELEPHONES 6.01	DATA PROCESSING 6.02	PURCHASING, RECEIVING AND STOR 6.03	ADMITTING 6.04	
1	ADMINISTRATIVE AND GENERAL				17209	1185		333		1
2	SKILLED NURSING CARE	198395			25664					2
3	PHYSICAL THERAPY	87427			11319					3
4	OCCUPATIONAL THERAPY	19031								4
5	SPEECH PATHOLOGY	3757								5
6	MEDICAL SOCIAL SERVICES	394								6
7	HOME HEALTH AIDE	529			80					7
8	SUPPLIES	4231								8
9	DRUGS									9
9.20	COST OF ADMINISTERING VACC									9.20
10	DME									10
11	HOME DIALYSIS AIDE SERVICE									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIE									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGR									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTALS	313764			54272	1185		333		20
21	UNIT COST MULTIPLIER									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
PART I

	HHA COST CENTER	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		6.05	5A	6.06	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL		18727	1458						1
2	SKILLED NURSING CARE		224059	17442						2
3	PHYSICAL THERAPY		98746	7687						3
4	OCCUPATIONAL THERAPY		19031	1481						4
5	SPEECH PATHOLOGY		3757	292						5
6	MEDICAL SOCIAL SERVICES		394	31						6
7	HOME HEALTH AIDE		609	47						7
8	SUPPLIES		4231	329						8
9	DRUGS									9
9.20	COST OF ADMINISTERING VACC									9.20
10	DME									10
11	HOME DIALYSIS AIDE SERVICE									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIE									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGR									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTALS		369554	28767						20
21	UNIT COST MULTIPLIER									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
PART I

	HHA COST CENTER	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL	
		14	15	16	17	18	25	26	27	
1	ADMINISTRATIVE AND GENERAL					5146	25331		25331	1
2	SKILLED NURSING CARE						241501		241501	2
3	PHYSICAL THERAPY						106433		106433	3
4	OCCUPATIONAL THERAPY						20512		20512	4
5	SPEECH PATHOLOGY						4049		4049	5
6	MEDICAL SOCIAL SERVICES						425		425	6
7	HOME HEALTH AIDE						656		656	7
8	SUPPLIES						4560		4560	8
9	DRUGS									9
9.20	COST OF ADMINISTERING VACC									9.20
10	DME									10
11	HOME DIALYSIS AIDE SERVICE									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIE									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGR									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTALS					5146	403467		403467	20
21	UNIT COST MULTIPLIER									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
PART I

	HHA COST CENTER	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29	
1	ADMINISTRATIVE AND GENERAL			1
2	SKILLED NURSING CARE	16179	257680	2
3	PHYSICAL THERAPY	7130	113563	3
4	OCCUPATIONAL THERAPY	1374	21886	4
5	SPEECH PATHOLOGY	271	4320	5
6	MEDICAL SOCIAL SERVICES	28	453	6
7	HOME HEALTH AIDE	44	700	7
8	SUPPLIES	305	4865	8
9	DRUGS			9
9.20	COST OF ADMINISTERING VACC			9.20
10	DME			10
11	HOME DIALYSIS AIDE SERVICE			11
12	RESPIRATORY THERAPY			12
13	PRIVATE DUTY NURSING			13
14	CLINIC			14
15	HEALTH PROMOTION ACTIVITIE			15
16	DAY CARE PROGRAM			16
17	HOME DELIVERED MEALS PROGR			17
18	HOMEMAKER SERVICE			18
19	ALL OTHERS			19
19.50	TELEMEDICINE			19.50
20	TOTALS	25331	403467	20
21	UNIT COST MULTIPLIER	.066989		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
STATISTICAL BASIS PART II

	HHA COST CENTER	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	NONPATIENT TELEPHONES #OF PHONES 6.01	DATA PROCESSING MACHINE TIME 6.02	PURCHASING, RECEIVING AND STOR COSTS SUPPLIES 6.03	ADMITTING INPATIENT CHARGES 6.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES 6.05	
1	ADMINISTRATIVE AND GENERAL			72654	4		5290			1
2	SKILLED NURSING CARE			108348						2
3	PHYSICAL THERAPY			47787						3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE			336						7
8	SUPPLIES									8
9	DRUGS									9
9.20	COST OF ADMINISTERING VACC									9.20
10	DME									10
11	HOME DIALYSIS AIDE SERVICE									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIE									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGR									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTALS			229125	4		5290			20
21	TOTAL COST TO BE ALLOCATED			54272	1185		333			21
22	UNIT COST MULTIPLIER			.236866						22
22	UNIT COST MULTIPLIER				296.250000		.062949			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
STATISTICAL BASIS PART II

	HHA COST CENTER	RECON-CILIATION	OTHER ADMINISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION HOURS OF SERVICE	
		6A.06	6.06	8	9	10	11	12	14	
1	ADMINISTRATIVE AND GENERAL		18727							1
2	SKILLED NURSING CARE		224059							2
3	PHYSICAL THERAPY		98746							3
4	OCCUPATIONAL THERAPY		19031							4
5	SPEECH PATHOLOGY		3757							5
6	MEDICAL SOCIAL SERVICES		394							6
7	HOME HEALTH AIDE		609							7
8	SUPPLIES		4231							8
9	DRUGS									9
9.20	COST OF ADMINISTERING VACC									9.20
10	DME									10
11	HOME DIALYSIS AIDE SERVICE									11
12	RESPIRATORY THERAPY									12
13	PRIVATE DUTY NURSING									13
14	CLINIC									14
15	HEALTH PROMOTION ACTIVITIE									15
16	DAY CARE PROGRAM									16
17	HOME DELIVERED MEALS PROGR									17
18	HOMEMAKER SERVICE									18
19	ALL OTHERS									19
19.50	TELEMEDICINE									19.50
20	TOTALS		369554							20
21	TOTAL COST TO BE ALLOCATED		28767							21
22	UNIT COST MULTIPLIER									22
22	UNIT COST MULTIPLIER		.077842							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS HHA NO.: 14-7167 WORKSHEET H-5
STATISTICAL BASIS PART II

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO 15	PHARMACY COSTED REQUISITIO 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
1	ADMINISTRATIVE AND GENERAL			690		1
2	SKILLED NURSING CARE					2
3	PHYSICAL THERAPY					3
4	OCCUPATIONAL THERAPY					4
5	SPEECH PATHOLOGY					5
6	MEDICAL SOCIAL SERVICES					6
7	HOME HEALTH AIDE					7
8	SUPPLIES					8
9	DRUGS					9
9.20	COST OF ADMINISTERING VACC					9.20
10	DME					10
11	HOME DIALYSIS AIDE SERVICE					11
12	RESPIRATORY THERAPY					12
13	PRIVATE DUTY NURSING					13
14	CLINIC					14
15	HEALTH PROMOTION ACTIVITIE					15
16	DAY CARE PROGRAM					16
17	HOME DELIVERED MEALS PROGR					17
18	HOMEMAKER SERVICE					18
19	ALL OTHERS					19
19.50	TELEMEDICINE					19.50
20	TOTALS			690		20
21	TOTAL COST TO BE ALLOCATED			5146		21
22	UNIT COST MULTIPLIER					22
22	UNIT COST MULTIPLIER			7.457971		22

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7167 WORKSHEET H-6
PARTS I & II

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

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

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-5, PART I, COL 29, LINE	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	257680		257680	1303	197.76	1
2	PHYSICAL THERAPY	3	113563		113563	876	129.64	2
3	OCCUPATIONAL THERAPY	4	21886		21886	171	127.99	3
4	SPEECH PATHOLOGY	5	4320		4320	35	123.43	4
5	MEDICAL SOCIAL SERV	6	453		453	2	226.50	5
6	HOME HEALTH AIDE SERV	7	700		700	9	77.78	6
7	TOTAL		398602		398602	2396		7

	LIMITATION COST COMPUTATION PATIENT SERVICES	MSA NO.	PROGRAM COST LIMITS	
		1	2	
8	SKILLED NURSING CARE	9914		8
9	PHYSICAL THERAPY	9914		9
10	OCCUPATIONAL THERAPY	9914		10
11	SPEECH PATHOLOGY	9914		11
12	MEDICAL SOCIAL SERV	9914		12
13	HOME HEALTH AIDE SERV	9914		13
14	TOTAL			14

	SUPPLIES AND DRUGS COST COMPUTATIONS OTHER PATIENT SERVICES	FROM WKST H-5, PART I, COL 29, LINE	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	4865		4865	4977	.977496	15
16	COST OF DRUGS	9						16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20

	PER BENEFICIARY COST LIMITATION:	MSA NO.	AMOUNT	
		1	2	
17	PROGRAM UNDUPLICATED CENSUS FROM WORKSHEET S-4	9914		17
18	PER BENEFICIARY COST LIMITATION	9914		18
19	PER BENEFICIARY COST LIMITATION			19

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7167 WORKSHEET H-6
PARTS I & II
(CONTINUED)

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

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

	COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES				
			PART B			PART B		TOTAL	
	PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PROGRAM COST	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	706	363		139619	71787		211406	1
2	PHYSICAL THERAPY	514	253		66635	32799		99434	2
3	OCCUPATIONAL THERAPY	104	49		13311	6272		19583	3
4	SPEECH PATHOLOGY	19	16		2345	1975		4320	4
5	MEDICAL SOCIAL SERV								5
6	HOME HEALTH AIDE SERV								6
7	TOTAL	1343	681		221910	112833		334743	7

	LIMITATION COST COMPUTATION	PROGRAM VISITS			COST OF SERVICES				
			PART B			PART B		TOTAL	
	PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PROGRAM COST	
		6	7	8	9	10	11	12	
8	SKILLED NURSING CARE								8
9	PHYSICAL THERAPY								9
10	OCCUPATIONAL THERAPY								10
11	SPEECH PATHOLOGY								11
12	MEDICAL SOCIAL SERV								12
13	HOME HEALTH AIDE SERV								13
14	TOTAL								14

	SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES				COST OF SERVICES				
			PART B DEDUCT. & COINSUR.				PART B DEDUCT. & COINSUR.			
	OTHER PATIENT SERVICES	PART A	FEE REIMBURSED	NOT SUBJECT TO	SUBJECT TO	PART A	FEE REIMBURSED	NOT SUBJECT TO	SUBJECT TO	
		6	7	7.01	8	9	10	10.01	11	
15	COST OF MEDICAL SUPPLIES	1392	2812			1361	2749			15
16	COST OF DRUGS									16
16.20	COST OF ADMINISTERING VA									16.20

APPORTIONMENT OF PATIENT SERVICE COSTS HHA NO.: 14-7167 WORKSHEET H-6
PARTS II & III

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

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

		FROM WKST C, PART I, COL 9, LINE	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I 4	
1	PHYSICAL THERAPY	50	.533351			COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY	51				COL 2, LINE 3	2
3	SPEECH PATHOLOGY	52				COL 2, LINE 4	3
4	MEDICAL SUPPLIES CHARGED TO PA	55	.106403			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	56	.317020			COL 2, LINE 16	5

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

				PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE					
				PROGRAM VISITS		PROGRAM COST		PROGRAM	
		FROM PART I COL. 5	COST PER VISIT	PRIOR TO 1/1/98	FROM 1/1/98 THRU 12/31/98	PRIOR TO 1/1/98	FROM 1/1/98 THRU 12/31/98	VISITS ON OR AFTER 1/1/99	
		1	2	2.01	3	3.01	4	5	
1	PHYSICAL THERAPY	2	129.64						1
2	OCCUPATIONAL THERAPY	3	127.99						2
3	SPEECH PATHOLOGY	4	123.43						3
4	TOTAL								4

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT HHA NO.: 14-7167 WORKSHEET H-7
PARTS I & II

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

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

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST			10
10.01	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	224494	112230	10.01
10.02	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03	TOTAL PPS REIMBURSEMENT - LUPA EPISODES		1776	10.03
10.04	TOTAL PPS REIMBURSEMENT - PEP EPISODES	409	1515	10.04
10.05	TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.05
10.06	TOTAL PPS REIMBURSEMENT - SCIC EPISODES		4674	10.06
10.07	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.07
10.08	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			10.08
10.09	TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.09
10.10	TOTAL PPS OUTLIER REIMBURSEMENT - SCIC EPISODES			10.10
10.11	TOTAL OTHER PAYMENTS			10.11
10.12	DME PAYMENTS			10.12
10.13	OXYGEN PAYMENTS			10.13
10.14	PROSTHETIC AND ORTHOTIC PAYMENTS			10.14
11	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCL COINSURANCE)			11
12	SUBTOTAL	224903	120195	12
13	EXCESS REASONABLE COST			13
14	SUBTOTAL	224903	120195	14
15	COINSURANCE BILLED TO PROGRAM PATIENTS			15
16	NET COST	224903	120195	16
17	REIMBURSABLE BAD DEBTS			17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	224903	120195	18
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			19
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR OR DECREASE IN PROGRAM UTILIZATION			20
21	OTHER ADJUSTMENTS (SPECIFY):			21
22	SUBTOTAL	224903	120195	22
23	SEQUESTRATION ADJUSTMENT			23
24	SUBTOTAL	224903	120195	24
25	TOTAL INTERIM PAYMENTS	224903	120195	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE PROVIDER/PROGRAM			26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			27

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7167 WORKSHEET H-8

	DESCRIPTION			PART A MO/DAY/YR 1	PART A AMOUNT 2	PART B MO/DAY/YR 3	PART B AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				224903		120195	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	.02					3.02
		TO	.03		NONE		NONE	3.03
		PROVIDER	.04					3.04
			.05					3.05
			.50					3.50
		PROVIDER	.51					3.51
		TO	.52		NONE		NONE	3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99					3.99
4	TOTAL INTERIM PAYMENTS				224903		120195	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		NONE		NONE	5.02
		PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		TO	.51		NONE		NONE	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				224903		120195	7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

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

		HOSPITAL (14-1326)	SUB I	SUB II	SUB III	SUB IV	
	PART I - FULLY PROSPECTIVE METHOD						
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS						1
	CAPITAL FEDERAL AMOUNT						
2	CAPITAL DRG OTHER THAN OUTLIER						2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED						3
	PRIOR TO OCTOBER 1, 1997						
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED						3.01
	ON OR AFTER OCTOBER 1, 1997						
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD						4
4.01	NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I						4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						4.02
4.03	INDIRECT MEDICAL EDUCATON ADJUSTMENT						4.03
	DISPROPORTIONATE SHARE ADJUSTMENT						
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS						5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I						5.01
5.02	SUM OF LINES 5 AND 5.01						5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT						5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS						6
	PART II - HOLD HARMLESS METHOD						
1	NEW CAPITAL						1
2	OLD CAPITAL						2
3	TOTAL CAPITAL						3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL						4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE						5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT						6
7	REDUCED OLD CAPITAL AMOUNT						7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL						8
9	SUBTOTAL						9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)						10
	PART III - PAYMENT UNDER REASONABLE COST						
1	PROGRAM INPATIENT ROUTINE CAPITAL COST						1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST						2
3	TOTAL INPATIENT PROGRAM CAPITAL						3
4	CAPITAL COST PAYMENT FACTOR						4
5	TOTAL INPATIENT PROGRAM CAPITAL COST						5
	PART IV - COMPUTATION OF EXCEPTION PAYMENTS						
1	PROGRAM INPATIENT CAPITAL COSTS						1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						2
3	NET PROGRAM INPATIENT CAPITAL COSTS						3
4	APPLICABLE EXCEPTION PERCENTAGE						4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS						5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES						6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR						7
	EXTRAORDINARY CIRCUMSTANCES						
8	CAPITAL MINIMUM PAYMENT LEVEL						8
9	CURRENT YEAR CAPITAL PAYMENTS						9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL						10
	TO CAPITAL PAYMENTS						
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL						11
	OVER CAPITAL PAYMENT						
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS						12
13	CURRENT YEAR EXCEPTION PAYMENT						13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL						14
	OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD						
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT						15
	(SEE INSTRUCTIONS)						
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)						16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT						17

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6.01	NONPATIENT TELEPHONES						6.01
6.02	DATA PROCESSING						6.02
6.03	PURCHASING RECEIVING AND STORES						6.03
6.04	ADMITTING						6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE						6.05
6.06	OTHER ADMINISTRATIVE AND GENERA						6.06
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
35	NURSING FACILITY						35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY						53
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	RURAL HEALTH CLINIC						63.50
	OTHER REIMBURSABLE COST CENTERS						
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
94	OTHER SPECIAL PURPOSE COST CENT						94
94.01	INSURANCE AND MALPRACTICE						94.01
94.02	SUPPLIES AND EXPENSE						94.02
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
98	PHYSICIANS' PRIVATE OFFICES						98
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: 14-3477

CHECK APPLICABLE BOX: [XX] RHC [ ] 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	174293		174293		174293		174293	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	81083		81083		81083		81083	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	58723		58723		58723		58723	9
10	SUBTOTAL (SUM OF LINES 1-9)	314099		314099		314099		314099	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		4480	4480		4480		4480	15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		4480	4480		4480		4480	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	314099	4480	318579		318579		318579	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		3144	3144		3144		3144	29
30	ADMINISTRATIVE COSTS	70319	92975	163294		163294		163294	30
31	TOTAL FACILITY OVERHEAD	70319	96119	166438		166438		166438	31
32	TOTAL FACILITY COSTS	384418	100599	485017		485017		485017	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3477

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	1.07	3512	4200	4494		1
2	PHYSICIAN ASSISTANTS	0.97	1813	2100	2037		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	2.04	5325		6531	6531	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	2.04	5325			6531	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	318579	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	318579	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD	166438	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	348600	15
16	TOTAL OVERHEAD	515038	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	515038	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	515038	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	833617	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3477

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	833617	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	6939	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	826678	3
4	TOTAL VISITS	6531	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	6531	6
7	ADJUSTED COST PER VISIT	126.58	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	126.58	126.58		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	697	697		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	88226	88226		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			176452	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			12376	17
18	NET PROGRAM COST EXCLUDING VACCINES			164076	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			131261	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			5671	20
21	TOTAL REIMBURSABLE PROGRAM COST			136932	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			136932	24
25	INTERIM PAYMENTS			94882	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			42050	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: 14-3477

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

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	314099	314099	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000060	0.001011	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	19	318	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	291	2024	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	310	2342	5
6	TOTAL DIRECT COST OF THE FACILITY	318579	318579	6
7	TOTAL OVERHEAD	515038	515038	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000973	0.007351	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	501	3786	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	811	6128	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	10	174	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	81.10	35.22	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	10	138	13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	811	4860	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		6939	15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		5671	16

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

RHC I COMPONENT NO: 14-3477

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				94882	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				94882	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		NONE	5.02
	PROVIDER	.03			5.03
	PROVIDER	.50			5.50
	TO	.51		NONE	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		42050	6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				136932	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	TITLE XVIII PART B	TITLE XIX INPATIENT	TITLE XIX OUTPATIENT	TITLE V INPATIENT	TITLE V OUTPATIENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	60.60		7.31				67.91	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	3.81	37.62	3.60				45.03	37
40	ANESTHESIOLOGY	4.27	18.28	5.18				27.73	40
41	RADIOLOGY-DIAGNOSTIC	10.85	25.56	1.54				37.95	41
44	LABORATORY	13.31	32.80	1.93				48.04	44
49	RESPIRATORY THERAPY	64.87	17.45	5.56				87.88	49
50	PHYSICAL THERAPY	9.23	23.11	0.24				32.58	50
53	ELECTROCARDIOLOGY	16.10	47.58	4.40				68.08	53
55	MEDICAL SUPPLIES CHARGED TO PAT	28.82	19.71	9.29				57.82	55
56	DRUGS CHARGED TO PATIENTS	36.26	20.38	4.42				61.06	56
61	EMERGENCY	0.54	34.66					35.20	61
62	OBSERVATION BEDS (NON-DISTINCT		43.96					43.96	62
101	TOTAL CHARGES	13.31	22.72	2.17				38.20	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT	190113	1.62	-190113	-3.98			3
4	NEW CAP REL COSTS-MVBLE EQUIP	531453	4.52	-531453	-11.12			4
5	EMPLOYEE BENEFITS	1477879	12.56	-1477879	-30.91			5
6.01	NONPATIENT TELEPHONES	23950	.20	-23950	-.50			6.01
6.02	DATA PROCESSING	83384	.71	-83384	-1.74			6.02
6.03	PURCHASING RECEIVING AND STORES	43110	.37	-43110	-.90			6.03
6.04	ADMITTING	113922	.97	-113922	-2.38			6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	248543	2.11	-248543	-5.20			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	639990	5.44	-639990	-13.39			6.06
8	OPERATION OF PLANT	432958	3.68	-432958	-9.06			8
9	LAUNDRY & LINEN SERVICE	111701	.95	-111701	-2.34			9
10	HOUSEKEEPING	121935	1.04	-121935	-2.55			10
11	DIETARY	80158	.68	-80158	-1.68			11
12	CAFETERIA							12
14	NURSING ADMINISTRATION	251418	2.14	-251418	-5.26			14
15	CENTRAL SERVICES & SUPPLY	7379	.06	-7379	-.15			15
16	PHARMACY	212747	1.81	-212747	-4.45			16
17	MEDICAL RECORDS & LIBRARY	168391	1.43	-168391	-3.52			17
18	SOCIAL SERVICE	42189	.36	-42189	-.88			18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1303328	11.08	1612964	33.74	2916292	24.79	25
35	NURSING FACILITY	1557280	13.24	592851	12.40	2150131	18.28	35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	165972	1.41	209911	4.39	375883	3.20	37
40	ANESTHESIOLOGY	258996	2.20	94388	1.97	353384	3.00	40
41	RADIOLOGY-DIAGNOSTIC	505056	4.29	353156	7.39	858212	7.30	41
44	LABORATORY	750500	6.38	364505	7.62	1115005	9.48	44
49	RESPIRATORY THERAPY	149516	1.27	112227	2.35	261743	2.22	49
50	PHYSICAL THERAPY	359394	3.06	191438	4.00	550832	4.68	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	3648	.03	10171	.21	13819	.12	53
55	MEDICAL SUPPLIES CHARGED TO PAT	100950	.86	34806	.73	135756	1.15	55
56	DRUGS CHARGED TO PATIENTS	326960	2.78	426858	8.93	753818	6.41	56
61	EMERGENCY	634085	5.39	302272	6.32	936357	7.96	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	485017	4.12	348600	7.29	833617	7.09	63.50
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY	313764	2.67	89703	1.88	403467	3.43	71
	SPECIAL PURPOSE COST CENTERS							
94	OTHER SPECIAL PURPOSE COST CENT							94
94.01	INSURANCE AND MALPRACTICE							94.01
94.02	SUPPLIES AND EXPENSE							94.02
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES	68189	.58	37370	.78	105559	.90	98

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	11763875	100.00	0	.00	11763875	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)	1596910
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)	4371424
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.365