

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

WORKSHEET S
 PARTS I & II

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

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 11/12/2008
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 10:11

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 ST. FRANCIS MEDICAL CENTER (26-0183) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2007 AND ENDING 06/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/12/2008 10:11
 z6fvbKJzoldDoli7.HP.kTmPoYXdPI0
 fHM460SQ3XAh5QEk:duvTNwMv6xVtw
 PoCYlgXnC30:rC1k

(SIGNED) Tom Balaban
 OFFICER OF ADMINISTRATOR OF PROVIDER(S)
 vice pres - finance
 11/19/08
 DATE

PI Encryption: 11/12/2008 10:11
 UuBFiYpvb:EXJQTSX.r6aGV9J7faQ0
 IjjEEOfoB0ZtS3aXxaSPKRRSm4Qxg0
 5w2RbRAUtr0Cyheh

PART II - SETTLEMENT SUMMARY

TITLE V	TITLE XVIII		TITLE XIX
	PART A	PART B	
1 HOSPITAL	2 856854	3 841	4 1
2 SUBPROVIDER I	11543		2
3 SWING BED - SNF			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 HEALTH CLINIC			9
100 TOTAL	868397	841	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 OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 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.

RECEIVED
 NOV 26 2008
 Healthcare & Family Services
 BUREAU OF HEALTH FINANCE

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
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(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		TITLE XIX 4	
		PART A 2	PART B 3		
1	HOSPITAL	856854	1024		1
2	SUBPROVIDER I	11543			2
3	SWING BED - SNF				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	HEALTH CLINIC				9
100	TOTAL	868397	1024		100

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 211 ST. FRANCIS DRIVE
 1.01 CITY: CAPE GIRARDEAU STATE: MO P.O.BOX: ZIP CODE: 63703 COUNTY: CAPE GIRARDEAU 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)			1	
				V 4	XVIII 5	XIX 6		
2	HOSPITAL	26-0183	07/01/1966	N	P	P	2	
3	SUBPROVIDER I	26-T183	07/01/1988	N	P	N	3	
4	SWING BEDS - SNF						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	HOME HEALTH AGENCY	26-7515	08/08/1996	N	P	N	9
11	SEPARATELY CERTIFIED ASC						11	
12	HOSPITAL-BASED HOSPICE						12	
14	HOSP-BASED RHC						14	
15	OUTPATIENT REHABILITATION PROVID						15	
16	RENAL DIALYSIS						16	
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 07/01/2007	TO: 06/30/2008			17	
18	TYPE OF CONTROL		1	2			18	

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL		1				19
20	SUBPROVIDER I		5				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?		YES				21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.		2		N		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?		YES				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:		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.	NO			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 1, 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.	NO			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.				30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?				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)				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.				30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31
31.01	IS THIS A RURAL HOSPITAL SUBPROVIDER QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31.01
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 (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	V	XVIII	XIX
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	1	2	3
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	YES	NO
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	NO

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. YES 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? NO 42
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 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? YES 44
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? NO 45
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC				
	1	2	3	4	5				
47 HOSPITAL	N	N	N	N	N	47			
48 SUBPROVIDER I	N	N	N	N	N	48			
49 SKILLED NURSING FACILITY	N	N	N	N	N	49			
50 HOME HEALTH AGENCY	N	N	N	N	N	50			
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?						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.						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: AND/OR SELF INSURANCE:						54			
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.						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.						55			
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.				DATE 0 / /	Y/N 1 NO	LIMIT 2 0.00	Y/N 3 NO	FEES 4	56
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?						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.						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)						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? NO 60
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)

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT 60.01
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.)

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/
1 2 3 4 CAMPUS
5

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS	
	TITLE V 12	TITLE XVIII 13	TITLE XIX 14			
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		5598	1502	10098		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
6.01 NEONATOLOGY/NICU						6.01
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		5598	1502	10098		12
13 RPCH VISITS						13
14 SUBPROVIDER I		218		293		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

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	WORKSHEET S-3 PART II
		1	2	3	4	5	6	
1	SALARIES							
1	TOTAL SALARIES	90353207		90353207	3250103.00	27.80		1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B	2527112		2527112	20346.00	124.21		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	15538629	641897	16180526	312634.00	51.76		8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	377918		377918	6639.00	56.92		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)	19095994		19095994			CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	2350550		2350550			CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B	297162		297162			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	678830	1119	679949	22718.00	29.93		21
22	ADMINISTRATIVE & GENERAL	7958947	-592248	7366699	317451.00	23.21		22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS	1627244	-316873	1310371	82744.00	15.84		23
24	OPERATION OF PLANT	537398	104	537502	31742.00	16.93		24
25	LAUNDRY & LINEN SERVICE	524268	69	524337	39071.00	13.42		25
26	HOUSEKEEPING	1462502	607	1463109	113313.00	12.91		26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	1474456	338	1474794	100424.00	14.69		27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	1613031	989	1614020	68485.00	23.57		30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	1169946	633	1170579	68412.00	17.11		33
34	SOCIAL SERVICE	298011	78	298089	10328.00	28.86		34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

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)	WORKSHEET S-3 PART III
		1	2	3	4	5	
1	NET SALARIES	87826095		87826095	3229757.00	27.19	1
2	EXCLUDED AREA SALARIES	15538629	641897	16180526	312634.00	51.76	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	72287466	-641897	71645569	2917123.00	24.56	3
4	SUBTOTAL OTHER WAGES & REL COSTS	377918		377918	6639.00	56.92	4
5	SUBTOTAL WAGE-RELATED COSTS	19095994		19095994		26.658	5
6	TOTAL (SUM OF LINES 3 THRU 5)	91761378	-641897	91119481	2923762.00	31.17	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	17344633	-905184	16439449	854688.00	19.23	13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 26-7515

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		24		3	27	1
2 UNDUPLICATED CENSUS COUNT		234.00		243.00	477.00	2

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

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTORS AND ASSISTANT DIRECTOR(S)	1.00		1.00	4
5 OTHER ADMINISTRATIVE PERSONNEL	1.00		1.00	5
6 DIRECT NURSING SERVICE	5.13		5.13	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE	1.91		1.91	8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE	.02		.02	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE	.03		.03	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE				14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	.02		.02	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

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	1.01	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)		9926	99926		20

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 26-7515

WORKSHEET S-4
 (CONTINUED)

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

	FULL EPISODES		LUPA EPISODES 3	PEP ONLY EPISODES 4	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL 7	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2						
21	SKILLED NURSING VISITS	1358	41	33		19	1451	21
22	SKILLED NURSING VISIT CHARGES	303580	9030	7310		5805	325725	22
23	PHYSICAL THERAPY VISITS	1489	29	37			1555	23
24	PHYSICAL THERAPY VISIT CHARGES	322715	6450	7955			337120	24
25	OCCUPATIONAL THERAPY VISITS	41	1	1			43	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	9245	215	215			9675	26
27	SPEECH PATHOLOGY VISITS	20	5				25	27
28	SPEECH PATHOLOGY VISIT CHARGES	4300	3010				7310	28
29	MEDICAL SOCIAL SERVICE VISITS							29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES							30
31	HOME HEALTH AIDE VISITS	21		3			24	31
32	HOME HEALTH AIDE VISIT CHARGES	2310		330			2640	32
33	TOTAL VISITS	2929	76	74		19	3098	33
34	OTHER CHARGES							34
35	TOTAL CHARGES	642150	18705	15810		5805	682470	35
36	TOTAL NUMBER OF EPISODES	227	26	5		1	259	36
37	TOTAL NUMBER OF OUTLIER EPISODES							37
38	TOTAL MEDICAL SUPPLY CHARGES	60593	678	3888		348	65507	38

NHCNQ DEMONSTRATION STATISTICAL DATA
 STATISTICAL DATA

WORKSHEET 5-7

GROUP	M3PI REVENUE CODE	SERVICES		SERVICES		TOTAL
		PRIOR TO JANUARY 1 RATE	1 DAYS 3.01	ON OR AFTER JANUARY 1 RATE	1 DAYS 4.01	
1	2	3		4		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

HOSPITAL UNCOMPENSATED CARE DATA

WORKSHEET S-10

UNCOMPENSATED CARE INFORMATION

1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	1
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	2
2.01	IS IT AT THE TIME OF ADMISSION?	2.01
2.02	IS IT AT THE TIME OF FIRST BILLING?	2.02
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	2.03
2.04	OTHER METHODS OF WRITE-OFFS (SPECIFY)	2.04
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	3
4	ARE CHARITY DETERMINATION BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	4
5	ARE CHARITY DETERMINATION BASED UPON INCOME DATA ONLY?	5
6	ARE CHARITY DETERMINATION BASED UPON NET WORTH DATA?	6
7	ARE CHARITY DETERMINATION BASED UPON INCOME AND NET WORTH DATA?	7
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	8
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	8.01
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	9
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	9.01
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	9.02
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	9.03
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	9.04
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE-OFF?	10
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER LINES 11 THRU 11.04	11
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	11.01
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	11.02
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	11.03
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	11.04
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	12
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	13
14	IS YOUR HOSPITAL STATE AND LOCAL GOVERNMENT OWNED? IF YES ANSWER LINE 14.01	14
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THE GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING UNCOMPENSATED CARE?	14.01
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	14.02
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	15
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	16
17	REVENUE RELATED TO UNCOMPENSATED CARE	17
17.01	GROSS MEDICAID REVENUES	15607024 17.01
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	18
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	19
20	RESTRICTED GRANTS	20
21	NON-RESTRICTED GRANTS	21
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	15607024 22
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	23
24	COST TO CHARGE RATIO	0.275630 24
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST	25
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	26
27	TOTAL SCHIP COST	27
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	79290771 28
29	TOTAL GROSS MEDICAID COST	21854915 29
30	OTHER UNCOMPENSATED CARE CHARGES (FROM YOUR RECORDS)	34514234 30
31	UNCOMPENSATED CARE COST	9513158 31
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	21854915 32

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

	COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
	GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT		336339	336339	50165	386504	-1316	385188	1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		6543274	6543274	3895961	10439235	-534790	9904445	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		7974642	7974642	124329	8098971	13153	8112124	4
5	0500 EMPLOYEE BENEFITS	678830	3511359	4190189	233577	4423766		4423766	5
6.01	0610 COMMUNICATIONS	203209	65844	269053	224100	493153	-36275	456878	6.01
6.02	0620 DATA PROCESSING	981474	1581036	2562510	2731	2565241		2565241	6.02
6.03	0630 PURCHASING	340684	313628	654312	-37575	616737		616737	6.03
6.04	0640 ADMITTING								6.04
6.05	0650 CREDIT & COLLECTIONS	647921	3203711	3851632	2797	3854429		3854429	6.05
6.06	0660 OTHER ADMINISTRATIVE & GENERAL	5785659	60871586	66657245	-11544919	55112326	-29537451	25574875	6.06
7	0700 MAINTENANCE & REPAIRS	1627244	999444	2626688	-479545	2147143		2147143	7
8	0800 OPERATION OF PLANT	241092	2538950	2780042	66	2780108	-5698	2774410	8
8.10	0801 SPD SOILED PROCESSING	296306	153499	449805	92	449897		449897	8.10
9	0900 LAUNDRY & LINEN SERVICE	524268	412514	936782	105	936887		936887	9
10	1000 HOUSEKEEPING	1462502	771261	2233763	919	2234682		2234682	10
11	1100 DIETARY	1474456	1623257	3097713	512	3098225	-983748	2114477	11
12	1200 CAFETERIA								12
14	1400 NURSING ADMINISTRATION	1141624	256373	1397997	854	1398851		1398851	14
14.10	1401 SPD STERILE PROCESSING	471407	357922	829329	643	829972	-200755	629217	14.10
17	1700 MEDICAL RECORDS & LIBRARY	1169946	720701	1890647	959	1891606	-277	1891329	17
18	1800 SOCIAL SERVICE	298011	73255	371266	118	371384		371384	18
	INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	15013466	4353693	19367159	40295	19407454		19407454	25
26	2600 INTENSIVE CARE UNIT	4530880	1262982	5793862	22747	5816609		5816609	26
26.01	2060 NEONATOLOGY/NICU	2787671	804663	3592334	22572	3614906		3614906	26.01
31	3100 SUBPROVIDER I	1197988	456199	1654187	4867	1659054	-35590	1623464	31
33	3300 NURSERY	830895	190782	1021677	4944	1026621		1026621	33
	ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM	5944016	3371477	9315493	78472	9393965		9393965	37
38	3800 RECOVERY ROOM	937536	280077	1217613	12192	1229805		1229805	38
39	3900 DELIVERY ROOM & LABOR ROOM	573467	138910	712377	5211	717588		717588	39
40	4000 ANESTHESIOLOGY	205194	373142	578336	1742	580078		580078	40
41	4100 RADIOLOGY-DIAGNOSTIC	2659364	2272922	4932286	7133	4939419	-77821	4861598	41
42	4200 RADIOLOGY-THERAPEUTIC	458449	567575	1026024		1026024	-2241	1023783	42
43	4300 RADIOISOTOPE	226247	156474	382721	536	383257	-147	383110	43
44	4400 LABORATORY	3101683	5925986	9027669	-223124	8804545		8804545	44
44.10	4401 CARDIOVASCULAR LABORATORY	2016723	911108	2927831	12910	2940741		2940741	44.10
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	2361369	1163644	3525013	35297	3560310	-107208	3453102	49
50	5000 PHYSICAL THERAPY	1589481	397529	1987010	3220	1990230	-32641	1957589	50
51	5100 OCCUPATIONAL THERAPY	672682	151690	824372	1846	826218		826218	51
52	5200 SPEECH PATHOLOGY	488876	110599	599475	1154	600629		600629	52
53	5300 ELECTROCARDIOLOGY	624645	761103	1385748	48545	1434293	-481895	952398	53
54	5400 ELECTROENCEPHALOGRAPHY	428658	435841	864499	4640	869139	-261931	607208	54
55	5500 MEDICAL SUPPLIES CHARGED TO PAT	545579	31696348	32241927	33049	32274976		32274976	55
56	5600 DRUGS CHARGED TO PATIENTS	2271015	8615833	10886848	21090	10907938	-12444	10895494	56
56.10	5601 REHABILITATION SERVICES	2170098	2116631	4286729	15670	4302399	-206630	4095769	56.10
	OUTPATIENT SERVICE COST CENTERS								
61	6100 EMERGENCY	6906599	1722695	8629294	16271	8645565	-2570807	6074758	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 RHC								63.50
63.60	6320 FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	6500 AMBULANCE SERVICES	428	245322	245750		245750		245750	65
67	6700 DURABLE MEDICAL EQUIP-SOLD	125352	1456872	1582224	131	1582355	-16336	1566019	67
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY	606742	216095	822837	906	823743		823743	71
	SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
88	8800 INTEREST EXPENSE		3704751	3704751	-3704751				88
90	9000 OTHER CAPITAL RELATED COSTS		365704	365704	-365704				90
95	SUBTOTALS	76619736	166535242	243154978	-11422250	231732728	-35092848	196639880	95
	NONREIMBURSABLE COST CENTERS								
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
96.01	9601 FITNESS CENTER	1084837	462550	1547387	3309	1550696		1550696	96.01
96.02	9602 RETAIL PHARMACY	569743	4349579	4919322	276	4919598		4919598	96.02
96.03	9603 GARDEN VIEW DELI	62135	136863	198998	26	199024		199024	96.03
96.04	9604 MEDICAL OFFICE BLDG				13	13		13	96.04

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	101
96.05 9605 PHYSICIAN SERVICES	2308204	320389	2628593	1989	2630582		2630582	96.05
96.06 9606 ENDOCRINOLOGIST	393131	139975	533106	776	533882		533882	96.06
96.07 9607 HOSPITALIST	1913786	577580	2491366	565	2491931		2491931	96.07
96.08 9608 NEONATOLOGY PHYSICIANS	1156922	134585	1291507	158	1291665		1291665	96.08
96.09 9609 ANESTHESIOLOGISTS	2319107	4950896	7270003	66	7270069		7270069	96.09
96.10 9610 PHYSICIAN CARDIOLOGIST		17668	17668		17668		17668	96.10
96.11 9611 PHYSICIAN ONCOLOGIST	1388918	4600589	5989507	3873	5993380		5993380	96.11
96.12 9612 PERINATOLOGY	476338	86627	562965	711	563676		563676	96.12
96.13 9613 TRAMA PHYSICIANS	1335808	262477	1598285	69	1598354		1598354	96.13
96.14 9614 LANDMARK HOSPITAL				16768	16768		16768	96.14
96.15 9615 GYN SURG ONCOLOGIST	522846	108646	631492	390	631882		631882	96.15
96.16 9616 CAPE GASTROENTEROLOGY	201696	43429	245125	1471	246596		246596	96.16
96.20 9617 NONPATIENT MEALS								96.20
96.30 9618 BEAUTY SHOP								96.30
96.40 9619 MARKETING COSTS				11391790	11391790		11391790	96.40
101 TOTAL	90353207	182727095	273080302		273080302	-35092848	237987454	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE			
			LINE #	SALARY	OTHER	
1	1	2	3	4	5	
1 RECLASS EMPLOYEE BENEFITS	A	EMPLOYEE BENEFITS	5		231883	1
2	A					2
3 RECLASS INTEREST EXPENSE	B	NEW CAP REL COSTS-BLDG & FIXT	3		3704751	3
4 RECLASS TELEPHONE COSTS	C	COMMUNICATIONS	6.01		222745	4
5 RECLASS MAIL CLERK	D	OTHER ADMINISTRATIVE & GENERA	6.06	38153		5
6 RECLASS MARKETING COST	E	MARKETING COSTS	96.40	617967	10773823	6
7 RECLASS BIOMED	F	EMPLOYEE BENEFITS	5	1119	575	7
8	F	COMMUNICATIONS	6.01	894	461	8
9	F	DATA PROCESSING	6.02	1805	926	9
10	F	PURCHASING	6.03	382	196	10
11	F	CREDIT & COLLECTIONS	6.05	1848	949	11
12	F	OTHER ADMINISTRATIVE & GENERA	6.06	20790	10673	12
13	F	MAINTENANCE & REPAIRS	7	28940	14856	13
14	F	OPERATION OF PLANT	8	43	23	14
15	F	SPD SOILED PROCESSING	8.10	61	31	15
16	F	LAUNDRY & LINEN SERVICE	9	69	36	16
17	F	HOUSEKEEPING	10	607	312	17
18	F	DIETARY	11	338	174	18
19	F	NURSING ADMINISTRATION	14	564	290	19
20	F	SPD STERILE PROCESSING	14.10	425	218	20
21	F	MEDICAL RECORDS & LIBRARY	17	633	326	21
22	F	SOCIAL SERVICE	18	78	40	22
23	F	ADULTS & PEDIATRICS	25	42384	21758	23
24	F	INTENSIVE CARE UNIT	26	17875	9176	24
25	F	NEONATOLOGY/NICU	26.01	14915	7657	25
26	F	SUBPROVIDER I	31	3275	1681	26
27	F	NURSERY	33	3267	1677	27
28	F	OPERATING ROOM	37	57970	29760	28
29	F	RECOVERY ROOM	38	8057	4135	29
30	F	DELIVERY ROOM & LABOR ROOM	39	3443	1768	30
31	F	ANESTHESIOLOGY	40	1151	591	31
32	F	RADIOLOGY-DIAGNOSTIC	41	4603	2363	32
33	F	RADIOLOGY-DIAGNOSTIC	41	134	69	33
34	F	RADIOISOTOPE	43	354	182	34
35	F	LABORATORY	44	5764	2959	35
36 SUBTOTAL				877908	15047064	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF. 10
			LINE #	SALARY	OTHER	
	1	6	7	8	9	
1 RECLASS EMPLOYEE BENEFITS	A	RADIOLOGY-DIAGNOSTIC	41		36	1
2	A	LABORATORY	44		231847	2
3 RECLASS INTEREST EXPENSE	B	INTEREST EXPENSE	88		3704751	11 3
4 RECLASS TELEPHONE COSTS	C	OTHER ADMINISTRATIVE & GENERA	6.06		222745	4
5 RECLASS MAIL CLERK	D	PURCHASING	6.03	38153		5
6 RECLASS MARKETING COST	E	OTHER ADMINISTRATIVE & GENERA	6.06	617967	10773823	6
7 RECLASS BIOMED	F					7
8	F					8
9	F					9
10	F					10
11	F					11
12	F					12
13	F					13
14	F					14
15	F					15
16	F					16
17	F					17
18	F					18
19	F					19
20	F					20
21	F					21
22	F					22
23	F					23
24	F					24
25	F					25
26	F					26
27	F					27
28	F					28
29	F					29
30	F					30
31	F					31
32	F					32
33	F					33
34	F					34
35	F					35
36 SUBTOTAL				656120	14933202	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
		COST CENTER	LINE #	SALARY	OTHER
	1	2	3	4	5
1	F	CARDIOVASCULAR LABORATORY	44.10	8837	4536 1
2	F	RESPIRATORY THERAPY	49	23324	11973 2
3	F	PHYSICAL THERAPY	50	2128	1092 3
4	F	OCCUPATIONAL THERAPY	51	1220	626 4
5	F	SPEECH PATHOLOGY	52	763	391 5
6	F	ELECTROCARDIOLOGY	53	1225	629 6
7	F	ELECTROENCEPHALOGRAPHY	54	3066	1574 7
8	F	MEDICAL SUPPLIES CHARGED TO P	55	21838	11211 8
9	F	DRUGS CHARGED TO PATIENTS	56	13936	7154 9
10	F	REHABILITATION SERVICES	56.10	10355	5315 10
11	F	EMERGENCY	61	16520	8481 11
12	F	DURABLE MEDICAL EQUIP-SOLD	67	87	44 12
13	F	HOME HEALTH AGENCY	71	599	307 13
14	F	FITNESS CENTER	96.01	2187	1122 14
15	F	RETAIL PHARMACY	96.02	182	94 15
16	F	GARDEN VIEW DELI	96.03	17	9 16
17	F	MEDICAL OFFICE BLDG	96.04	9	4 17
18	F	PHYSICIAN SERVICES	96.05	1314	675 18
19	F	ENDOCRINOLOGIST	96.06	513	263 19
20	F	HOSPITALIST	96.07	373	192 20
21	F	NEONATOLOGY PHYSICIANS	96.08	104	54 21
22	F	ANESTHESIOLOGISTS	96.09	43	23 22
23	F	PHYSICIAN ONCOLOGIST	96.11	2560	1313 23
24	F	PERINATOLOGY	96.12	470	241 24
25	F	TRAMA PHYSICIANS	96.13	45	24 25
26	F	LANDMARK HOSPITAL	96.14	11080	5688 26
27	F	GYN SURG ONCOLOGIST	96.15	258	132 27
28	F	CAPE GASTROENTEROLOGY	96.16	972	499 28
29 RECLASS EKG COSTS	H	ELECTROCARDIOLOGY	53	38747	7944 29
30	H				30
31	H				31
32	H				32
33	H				33
34	H				34
35	H				35
36 TOTAL RECLASSIFICATIONS				1040680	15118674 36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE			WKST A-7 REF. 10	
			COST CENTER 6	LINE # 7	SALARY 8		OTHER 9
1		F				1	
2		F				2	
3		F				3	
4		F				4	
5		F				5	
6		F				6	
7		F				7	
8		F				8	
9		F				9	
10		F				10	
11		F				11	
12		F				12	
13		F				13	
14		F				14	
15		F				15	
16		F				16	
17		F				17	
18		F				18	
19		F				19	
20		F				20	
21		F				21	
22		F				22	
23		F				23	
24		F				24	
25		F				25	
26		F				26	
27		F				27	
28		F	MAINTENANCE & REPAIRS	7	345813	177528	28
29	RECLASS EKG COSTS	H					29
30		H	ADULTS & PEDIATRICS	25	19709	4138	30
31		H	INTENSIVE CARE UNIT	26	3662	642	31
32		H	SUBPROVIDER I	31	71	18	32
33		H	OPERATING ROOM	37	7502	1756	33
34		H	CARDIOVASCULAR LABORATORY	44.10	372	91	34
35		H	EMERGENCY	61	7431	1299	35
36	TOTAL RECLASSIFICATIONS				1040680	15118674	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 -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	64377					64377		1
2 LAND IMPROVEMENTS	1849079					1849079		2
3 BUILDINGS AND FIXTURES	17342802				468153	16874649		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	14771303				115871	14655432		5
6 MOVABLE EQUIPMENT	4885836				1699826	3186010		6
7 SUBTOTAL	38913397				2283850	36629547		7
8 RECONCILING ITEMS								8
9 TOTAL	38913397				2283850	36629547		9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	2604493	182998		182998		2787491		1
2 LAND IMPROVEMENTS	4223208	217024		217024		4440232		2
3 BUILDINGS AND FIXTURES	64219900	24362407		24362407	18517776	70064531		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	50714010	4588654		4588654	2577876	52724788		5
6 MOVABLE EQUIPMENT	69047836	13876486		13876486	3382295	79542027		6
7 SUBTOTAL	190809447	43227569		43227569	24477947	209559069		7
8 RECONCILING ITEMS								8
9 TOTAL	190809447	43227569		43227569	24477947	209559069		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	
	1	2	3	4	5	6	7	
1 OLD CAP REL COSTS-BLDG & FIXT	33379160		33379160	.137173			50165	50165 1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	127229551		127229551	.522854			191210	191210 3
4 NEW CAP REL COSTS-MVBLE EQUIP	82728037		82728037	.339973			124329	124329 4
5 TOTAL	243336748		243336748	1.000000			365704	365704 5

SUMMARY OF OLD AND NEW CAPITAL

DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
	1 OLD CAP REL COSTS-BLDG & FIXT	335023					50165
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	6528056		3185179			191210	9904445 3
4 NEW CAP REL COSTS-MVBLE EQUIP	7987795					124329	8112124 4
5 TOTAL	14850874		3185179			365704	18401757 5

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

SUMMARY OF OLD AND NEW CAPITAL

DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
	1 OLD CAP REL COSTS-BLDG & FIXT	336339					
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	6543274						6543274 3
4 NEW CAP REL COSTS-MVBLE EQUIP	7974642						7974642 4
5 TOTAL	14854255						14854255 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	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	-519572	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					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-36275	COMMUNICATIONS	6.01	9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-3589827			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1	-1316			14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-983748	DIETARY	11	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-12444	DRUGS CHARGED TO PATIENTS	56	19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-277	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST				
	A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST				
	WKST A-8-4				36
37 DEPR. ON PT. PHONE	A	-3350	NEW CAP REL COSTS-MVBLE EQUIP	4	9 37
38 TELEVISION ELECTRIC USAGE	A	-5698	OPERATION OF PLANT	8	38
39					39
40 COMMUNITY WELLNESS	B	-76869	REHABILITATION SERVICES	56.10	40
41 OUTSIDE STERILE PROCESS	B	-200755	SPD STERILE PROCESSING	14.10	41
42 APPRIA - LABOR	B	-14980	DURABLE MEDICAL EQUIP-SOLD	67	42
43 COMMUNITY TRAINING CENTER	B	-64950	REHABILITATION SERVICES	56.10	43
44 SPEC. EDUC. REIMB	B	-17051	OTHER ADMINISTRATIVE & GENERAL	6.06	44
45 MISC. INCOME	B	-43415	OTHER ADMINISTRATIVE & GENERAL	6.06	45
46 NON-ALLOW SUPPLIES-REHAB.	B	-11486	REHABILITATION SERVICES	56.10	46
47 SPORTS MED ACC. PROG.	B	-32641	PHYSICAL THERAPY	50	47
48 DME-SUPPLIES SALE	B	-1356	DURABLE MEDICAL EQUIP-SOLD	67	48
49 REHAB GYM USE	B	-1138	REHABILITATION SERVICES	56.10	49
49.01 ADJ. DEPR. EXP.	A	-9094	NEW CAP REL COSTS-BLDG & FIXT	3	9 49.01
49.02 ADJ. DEPR. EXP.	A	-2730	NEW CAP REL COSTS-MVBLE EQUIP	4	9 49.02
49.03 PROVISION FOR BAD DEBTS	A	-29460848	OTHER ADMINISTRATIVE & GENERAL	6.06	49.03
49.04 ADJ. DEPR. EXP	A	22577	NEW CAP REL COSTS-MVBLE EQUIP	4	9 49.04
49.05 AHA DUES FOR LOBBYING	A	-14372	OTHER ADMINISTRATIVE & GENERAL	6.06	49.05
49.06 DEPR. NEW BLDG & FIX.	A	-6124	NEW CAP REL COSTS-BLDG & FIXT	3	9 49.06
49.07 DEPR. NEW MOV. EQUIP.	A	-3344	NEW CAP REL COSTS-MVBLE EQUIP	4	9 49.07
49.08 NON-ALLOWABLE EXPENSE	A	-1765	OTHER ADMINISTRATIVE & GENERAL	6.06	49.08
50 TOTAL		-35092848			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	OLD CAP REL COSTS-BLDG & FIXT		1316	-1316	9
2						2
3						3
4						4
5		TOTALS		1316	-1316	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	
E	SFMC		SFHS		HEALTHCARE	1
						2
						3
						4
						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	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	31 SUBPROVIDER I			71285		484		
					153400		35695	1785
2	41 RADIOLOGY-DIAGNOSTIC	77821	77821		195000			
3	42 RADIOLOGY-THERAPEUTIC	2241	2241		195000			
4	49 RESPIRATORY THERAPY	107208	107208		153400			
5	53 ELECTROCARDIOLOGY	481895	481895		153400			
6	54 ELECTROENCEPHALOGRAPHY	261931	261931		153400			
7	56.10 REHABILITATION SERVICES	81097		81097	153400	392	28910	1446
8	61 EMERGENCY	2580247	2560023	20224	153400	128	9440	472
9	43 RADIOISOTOPE		147	147	153400			
101	TOTAL	3663872	3491266	172606		1004	74045	3703

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.	11	12	13	14	15	16	17	18
1	31 SUBPROVIDER I					35695	35590	35590
2	41 RADIOLOGY-DIAGNOSTIC							77821
3	42 RADIOLOGY-THERAPEUTIC							2241
4	49 RESPIRATORY THERAPY							107208
5	53 ELECTROCARDIOLOGY							481895
6	54 ELECTROENCEPHALOGRAPHY							261931
7	56.10 REHABILITATION SERVICES					28910	52187	52187
8	61 EMERGENCY					9440	10784	2570807
9	43 RADIOISOTOPE							147
101	TOTAL					74045	98561	3589827