National Government Services, Inc.
Cost Reporting Unit
PO Box 7149
Indianapolis, IN 46207-7149

Dear Sir or Madam:

This cost report of Hamilton Memorial Hospital for the fiscal year ended June 30, 2009 includes two Level 2000 Errors.

2027 Worksheet C, Part I, Line 40, Col 11 should not be more than 100% or less than 1%.

The Hospital's anesthesiology cost to charge ratio was 1.351386 as the number of surgeries in 2009 did not generate enough revenue to cover the expense of the CRNA's including allocated overhead. As a rural hospital Hamilton Memorial Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower surgery volumes.

2027 Worksheet C, Part I, Line 63.50, Col 11 should not be more than 100% or less than 1%.

The Hospital's rural health clinic cost to charge ratio was 1.988293 as the number of visits in 2009 did not generate enough revenue to cover the expense of the clinic including allocated overhead. As a rural hospital Hamilton Memorial Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower clinic volumes which operate in rural underserved areas.

HAMILTON MEMORIAL HOSPITAL

MCLEANSBORO, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2009

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

WORKSHEET S
PARTS I & II

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

PART I - CERTIFICATION

CHECK APPLICABLE BOX	XX ELECTRONICALLY FILED COST REPORT	DATE: _09/10/2009
	__ MANUALLY SUBMITTED COST REPORT	TIME: _09:39____

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 07/01/2008 AND ENDING 06/30/2009, 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: 09/10/2009 09:39
Yrmi.hFUGmtcP8bPFnTrld9PmeccK0
.IFTO09c4C0s3qZ63SmkSOPE52GX9e
Uo2W0ePPCP0omFLV

PI Encryption: 09/10/2009 09:39
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		302485	129804		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		105141			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			37777		9
100	TOTAL		407626	167581		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.

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 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6	
2	HOSPITAL	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: 07/01/2008 TO: 06/30/2009 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: PREMIUMS: 161051 PAID LOSSES: AND/OR SELF INSURANCE:		54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

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

MULTICAMPUS

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

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

SETTLEMENT DATA

63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	NO	63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9125	73248.00		2403		339		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					743				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9125	73248.00		3146		339		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	9125	73248.00		3146		339		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY	60	21900							16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY					1742				18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC 1					1387				24
25	TOTAL	85								25
26	OBSERVATION BED DAYS							152	30	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 / O/P VISITS / TRIPS---- OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	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		3052								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		743								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		147								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3942								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		3942						120.24		12
13	RPCH VISITS										13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY										15
16	NURSING FACILITY		13998						54.58		16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY		2130						4.73		18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I		4178						8.34		24
25	TOTAL								187.89		25
26	OBSERVATION BED DAYS	122	798	237	561						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART 1
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		764	146	1052	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		764	146	1052	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	6655044						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES	1509181						8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR							9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A							10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS							11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)						CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS						CMS 339	15
16	NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17	NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18	PHYSICIAN PART A						CMS 339	18
18.01	PART A TEACHING PHYSICIANS						CMS 339	18.01
19	PHYSICIAN PART B						CMS 339	19
19.01	WAGE RELATED COSTS (RHC/FQHC)							19.01
20	INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS							21
22	ADMINISTRATIVE & GENERAL	719031	1877					22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	152653						24
25	LAUNDRY & LINEN SERVICE	80699						25
26	HOUSEKEEPING	107923						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	15514	-1877					27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	276739						30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY	174793						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	161931						33
34	SOCIAL SERVICE	41563						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	6655044		6655044			1
2	EXCLUDED AREA SALARIES	1509181		1509181			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5145863		5145863			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	5145863		5145863			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	1730846		1730846			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		33			33	1
2	UNDUPLICATED CENSUS COUNT		84.00		23.00	107.00	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)	.89		.89	3
4	DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	1.03		1.03	5
6	DIRECT NURSING SERVICE	2.13		2.13	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	.72		.72	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	636		29				665	21
22	SKILLED NURSING VISIT CHARGES	69960		3190				73150	22
23	PHYSICAL THERAPY VISITS	680			1			681	23
24	PHYSICAL THERAPY VISIT CHARGES	74800			110			74910	24
25	OCCUPATIONAL THERAPY VISITS	363						363	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	39930						39930	26
27	SPEECH PATHOLOGY VISITS	30						30	27
28	SPEECH PATHOLOGY VISIT CHARGES	3300						3300	28
29	MEDICAL SOCIAL SERVICE VISITS								29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES								30
31	HOME HEALTH AIDE VISITS	33						33	31
32	HOME HEALTH AIDE VISIT CHARGES	2970						2970	32
33	TOTAL VISITS	1742		29	1			1772	33
34	OTHER CHARGES								34
35	TOTAL CHARGES	190960		3190	110			194260	35
36	TOTAL NUMBER OF EPISODES	100		10	1			111	36
37	TOTAL NUMBER OF OUTLIER EPISODES								37
38	TOTAL MEDICAL SUPPLY CHARGES	3029		630				3659	38

RHC I
COMPONENT NO: 14-3477

WORKSHEET S-8

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

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? NO 11
IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
(ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

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

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

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

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		358549	358549	-29618	328931		328931	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		481527	481527	84934	566461	-22552	543909	4
5	0500	EMPLOYEE BENEFITS		2014314	2014314		2014314	-36377	1977937	5
6.01	0610	NONPATIENT TELEPHONES		30651	30651	-4598	26053		26053	6.01
6.02	0620	DATA PROCESSING	66171	15191	81362		81362		81362	6.02
6.03	0630	PURCHASING RECEIVING AND STORES	41023	3456	44479		44479	-239	44240	6.03
6.04	0640	ADMITTING				120166	120166		120166	6.04
6.05	0650	CASHIERING/ACCOUNTS RECEIVABLE	188302	197536	385838	-120166	265672		265672	6.05
6.06	0660	OTHER ADMINISTRATIVE AND GENERA	423535	276077	699612	179275	878887	-157867	721020	6.06
8	0800	OPERATION OF PLANT	152653	360245	512898	-1964	510934		510934	8
9	0900	LAUNDRY & LINEN SERVICE	80699	37142	117841		117841		117841	9
10	1000	HOUSEKEEPING	107923	22929	130852		130852		130852	10
11	1100	DIETARY	15514	84488	100002	-12100	87902		87902	11
12	1200	CAFETERIA								12
14	1400	NURSING ADMINISTRATION	276739	21037	297776		297776		297776	14
15	1500	CENTRAL SERVICES & SUPPLY		2886	2886	8056	10942		10942	15
16	1600	PHARMACY	174793	418801	593594	-393489	200105		200105	16
17	1700	MEDICAL RECORDS & LIBRARY	161931	48338	210269		210269	-4575	205694	17
18	1800	SOCIAL SERVICE	41563	5048	46611		46611		46611	18
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	1254433	79903	1334336		1334336		1334336	25
35	3500	NURSING FACILITY	1285574	290541	1576115	53998	1630113	-7014	1623099	35
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	139387	122483	261870	-100014	161856		161856	37
40	4000	ANESTHESIOLOGY	225242	32282	257524	-5160	252364		252364	40
41	4100	RADIOLOGY-DIAGNOSTIC	296783	255560	552343		552343		552343	41
44	4400	LABORATORY	339198	445371	784569		784569		784569	44
49	4900	RESPIRATORY THERAPY	134541	27694	162235	-2364	159871		159871	49
50	5000	PHYSICAL THERAPY	265151	150913	416064	-3	416061		416061	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY		4097	4097		4097		4097	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				71876	71876	-10347	61529	55
56	5600	DRUGS CHARGED TO PATIENTS				356934	356934	-35824	321110	56
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	170732	697077	867809	70520	938329	-276251	662078	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC	589550	67957	657507	-87791	569716	-95219	474497	63.50
		OTHER REIMBURSABLE COST CENTERS								
71	7100	HOME HEALTH AGENCY	223607	101588	325195	1369	326564	-729	325835	71
		SPECIAL PURPOSE COST CENTERS								
88	8800	INTEREST EXPENSE		17356	17356	-17356				88
90	9000	OTHER CAPITAL RELATED COSTS		27728	27728	-27728				90
94	6950	OTHER SPECIAL PURPOSE COST CENT								94
94.01	6951	INSURANCE AND MALPRACTICE		136721	136721	-136721				94.01
94.02	6952	SUPPLIES AND EXPENSE		8056	8056	-8056				94.02
95		SUBTOTALS	6655044	6843542	13498586		13498586	-646994	12851592	95
		NONREIMBURSABLE COST CENTERS								
98	9800	PHYSICIANS' PRIVATE OFFICES		68738	68738		68738		68738	98
101		TOTAL	6655044	6912280	13567324		13567324	-646994	12920330	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-MVBLE EQUIP	4		17356	1
2	TO RECLASS CAFETERIA COSTS	B	OTHER ADMINISTRATIVE AND GENE	6.06	1877	10223	2
3	TO RECLASS RENT EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		101807	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		170833	9
10		D					10
11		D					11
12	TO RECLASS SALARIES & OTHER EXP	E	ADMITTING	6.04	62705	57461	12
13	TO RECLASS SUPPLIES SOLD TO PATIENTS	F	MEDICAL SUPPLIES CHARGED TO P	55		71876	13
14		F					14
15		F					15
16		F					16
17		F					17
18		F					18
19		F					19
20	TO RECLASS DRUGS TO PHARMACY	G	DRUGS CHARGED TO PATIENTS	56		329639	20
21	TO RECLASS SUPPLIES SOLD	H	CENTRAL SERVICES & SUPPLY	15		8056	21
22	TO RECLASS NURSING CENTER PHONES	I	NURSING FACILITY	35		4598	22
23	TO RECLASS NURSING CENTER DEPRECIATI	J	NURSING FACILITY	35		76211	23
24		J					24
25	TO RECLASS IV COSTS	K	DRUGS CHARGED TO PATIENTS	56		27327	25
26	TO RECLASS AUDIT COST	L	OTHER ADMINISTRATIVE AND GENE	6.06		6694	26
27		L					27
28	TO RECLASS HHA DEPRECIATION	M	HOME HEALTH AGENCY	71		15364	28
29	TO RECLASS MALPRACTICE INSURANCE	N	OTHER ADMINISTRATIVE AND GENE	6.06		10304	29
30	TO RECLASS ER TIME FOR RHC PHYS	O	EMERGENCY	61	77485		30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				142067	907749	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		17356	11 1
2	TO RECLASS CAFETERIA COSTS	B	DIETARY	11	1877	10223	2
3	TO RECLASS RENT EXPENSE	C	OTHER ADMINISTRATIVE AND GENE	6.06		20656	10 3
4		C	OPERATING ROOM	37		40701	4
5		C	RESPIRATORY THERAPY	49		1963	5
6		C	PHARMACY	16		36523	6
7		C	OPERATION OF PLANT	8		1964	7
8		C					8
9	TO RECLASS INSURANCE EXPENSE	D	INSURANCE AND MALPRACTICE	94.01		136721	9
10		D	NURSING FACILITY	35		23464	10
11		D	HOME HEALTH AGENCY	71		10648	11
12	TO RECLASS SALARIES & OTHER EXP	E	CASHIERING/ACCOUNTS RECEIVABL	6.05	62705	57461	12
13	TO RECLASS SUPPLIES SOLD TO PATIE	F	EMERGENCY	61		6965	13
14		F	ANESTHESIOLOGY	40		5160	14
15		F	OPERATING ROOM	37		59313	15
16		F	RESPIRATORY THERAPY	49		401	16
17		F	PHYSICAL THERAPY	50		3	17
18		F	DRUGS CHARGED TO PATIENTS	56		32	18
19		F	RURAL HEALTH CLINIC	63.50		2	19
20	TO RECLASS DRUGS TO PHARMACY	G	PHARMACY	16		329639	20
21	TO RECLASS SUPPLIES SOLD	H	SUPPLIES AND EXPENSE	94.02		8056	21
22	TO RECLASS NURSING CENTER PHONES	I	NONPATIENT TELEPHONES	6.01		4598	22
23	TO RECLASS NURSING CENTER DEPRECI	J	NEW CAP REL COSTS-BLDG & FIXT	3		49084	9 23
24		J	NEW CAP REL COSTS-MVBLE EQUIP	4		27127	9 24
25	TO RECLASS IV COSTS	K	PHARMACY	16		27327	25
26	TO RECLASS AUDIT COST	L	NURSING FACILITY	35		3347	26
27		L	HOME HEALTH AGENCY	71		3347	27
28	TO RECLASS HHA DEPRECIATION	M	NEW CAP REL COSTS-MVBLE EQUIP	4		15364	9 28
29	TO RECLASS MALPRACTICE INSURANCE	N	RURAL HEALTH CLINIC	63.50		10304	29
30	TO RECLASS ER TIME FOR RHC PHYS	O	RURAL HEALTH CLINIC	63.50	77485		30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				142067	907749	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	74449					74449		1
2	LAND IMPROVEMENTS	600029	7304		7304		607333		2
3	BUILDINGS AND FIXTURES	5265332	6653424		6653424		11918756		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	4937184	525296		525296	145757	5316723		6
7	SUBTOTAL	10876994	7186024		7186024	145757	17917261		7
8	RECONCILING ITEMS								8
9	TOTAL	10876994	7186024		7186024	145757	17917261		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	ALLOCATION OF OTHER CAPITAL: INSURANCE 5	TAXES 6	OTHER CAPITAL-RELATED COSTS 7	TOTAL 8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT	12526086		12526086	.702024	19466			19466	3
4	NEW CAP REL COSTS-MVBLE EQUIP	5316723		5316723	.297976	8262			8262	4
5	TOTAL	17842809		17842809	1.000000	27728			27728	5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL-RELATED COSTS 14	TOTAL 15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	289960			38971			328931	3
4	NEW CAP REL COSTS-MVBLE EQUIP	425561	101807		16541			543909	4
5	TOTAL	715521	101807		55512			872840	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL-RELATED COSTS 14	TOTAL 15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	339044			19505			358549	3
4	NEW CAP REL COSTS-MVBLE EQUIP	473248			8279			481527	4
5	TOTAL	812292			27784			840076	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B	-17356	NEW CAP REL COSTS-MVBLE EQUIP	4	11	4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS	B	-239	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	-1347	OTHER ADMINISTRATIVE AND GENERA	6.06		10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-245257				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						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-10347	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-35824	DRUGS CHARGED TO PATIENTS	56		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4575	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	B	-2003	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			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		OCCUPATIONAL THERAPY	51		35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		SPEECH PATHOLOGY	52		36
37	COMMUNITY PROGRAM	B	-2624	OTHER ADMINISTRATIVE AND GENERA	6.06		37
38	HH COMMUNITY PROGRAM	B	-729	HOME HEALTH AGENCY	71		38
39	PORTION OF LOBBYING DUES	A	-4828	OTHER ADMINISTRATIVE AND GENERA	6.06		39
40	WOMENS WELLNESS	B	-32632	OTHER ADMINISTRATIVE AND GENERA	6.06		40
41	PHYSICIAN RECRUITMENT	A	-34111	OTHER ADMINISTRATIVE AND GENERA	6.06		41
42	ADVERTISING	A	-36337	OTHER ADMINISTRATIVE AND GENERA	6.06		42
43	IDPA ASSESSMENTS	A	32850	OTHER ADMINISTRATIVE AND GENERA	6.06		43
44	BEAUTY SHOP	A	-5778	NURSING FACILITY	35		44
45							45
46	FUNDRAISING	A	-5196	NEW CAP REL COSTS-MVBLE EQUIP	4	9	46
47	NH DIETARY	B	-1122	NURSING FACILITY	35		47
48							48
49	NH SUPPLY TO OTHERS	B	-14	NURSING FACILITY	35		49
49.02	SURETY BOND	A	-100	NURSING FACILITY	35		49.02
49.03	FUND/MKT SALARIES	A	-39136	OTHER ADMINISTRATIVE AND GENERA	6.06		49.03
49.04	FUND/MKT BENEFITS	A	-8610	EMPLOYEE BENEFITS	5		49.04
49.06	FUNDRAISING	A	-37699	OTHER ADMINISTRATIVE AND GENERA	6.06		49.06
49.07	RHC ER SALARIES	A	-30994	EMERGENCY	61		49.07
49.08	RHC ER BENEFITS	A	-6819	EMPLOYEE BENEFITS	5		49.08
49.09	NON RHC COST	A	-95219	RURAL HEALTH CLINIC	63.50		49.09
49.10	NON RHC BENEFITS	A	-20948	EMPLOYEE BENEFITS	5		49.10
50	TOTAL		-646994				50

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERA-TION INCL FRINGES 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNAD-JUSTED RCE LIMIT 8	PERCENT OF UNAD-JUSTED RCE LIMIT 9
2	61	EMERGENCY	AGGREGATE	613143	245257	367886				
101		TOTAL		613143	245257	367886				

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							245257
101		TOTAL								245257

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

WORKSHEET A-8-4
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	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	253	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		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		2569.50				9
10	AHSEA		63.22				10
11	STANDARD TRAVEL ALLOWANCE	31.61	31.61				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	162444	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	162444	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	162444	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	162444	23

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

WORKSHEET A 8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	7997	24
25	ASSISTANTS		25
26	SUBTOTAL	7997	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	7997	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	7997	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
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	162444	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	7997	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	170441	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	108416	64
65	EXCESS OVER LIMITATION		65

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

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	80808	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	27608	66.31
67	TOTAL COST	108416	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.745351	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.254649	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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

WORKSHEET A-8-4
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	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	64	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	86	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	4.53	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		717.25				9
10	AHSEA		66.72				10
11	STANDARD TRAVEL ALLOWANCE	33.36	33.36				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	47855	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	47855	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	47855	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.72	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	52042	22
23	TOTAL SALARY EQUIVALENCY	52042	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	2135	24
25	ASSISTANTS		25
26	SUBTOTAL	2135	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	2135	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	2135	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	2869	36
37	ASSISTANTS		37
38	SUBTOTAL	2869	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	2869	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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

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

[ ] 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	52042	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	2135	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	2869	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	57046	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	49448	64
65	EXCESS OVER LIMITATION		65

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

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

[ ] 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	45008	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	4440	66.31
67	TOTAL COST	49448	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.910209	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.089791	68.31
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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

WORKSHEET A-8-4
PARTS I & II

[ ] OCCUPATIONAL [ ] 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	144	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	2	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	4.53	8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		255.00				9
10	AHSEA		60.76				10
11	STANDARD TRAVEL ALLOWANCE	30.38	30.38				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	15494	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	15494	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	15494	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	60.76	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	47393	22
23	TOTAL SALARY EQUIVALENCY	47393	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4375	24
25	ASSISTANTS		25
26	SUBTOTAL	4375	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4375	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	4375	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	61	36
37	ASSISTANTS		37
38	SUBTOTAL	61	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	61	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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

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

[ ] 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	47393	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	4375	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	61	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	51829	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	13972	64
65	EXCESS OVER LIMITATION		65

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

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

[ ] 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	12619	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	1353	66.31
67	TOTAL COST	13972	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.903163	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.096837	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 STORING 6.03	ADMITTING 6.04	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	328931	328931							3
4	NEW CAP REL COSTS-MVBLE EQUIP	543909		543909						4
5	EMPLOYEE BENEFITS	1977937			1977937					5
6.01	NONPATIENT TELEPHONES	26053	289	479		26821				6.01
6.02	DATA PROCESSING	81362	926	1532	20163	323	104306			6.02
6.03	PURCHASING RECEIVING AND STORES	44240	11847	19589	12500	646		88822		6.03
6.04	ADMITTING	120166	854	1412	19107				141539	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	265672	4168	6893	38271	969	84618			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	721020	34910	57726	118142	4525	19688	4269		6.06
8	OPERATION OF PLANT	510934	40453	66852	46516	646		2625		8
9	LAUNDRY & LINEN SERVICE	117841	6918	11440	24590	323		115		9
10	HOUSEKEEPING	130852			32886			1167		10
11	DIETARY	87902	4668	7718	4155	646		132		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION	297776	6549	10830	84326	1293		66		14
15	CENTRAL SERVICES & SUPPLY	10942	1983	3279				199		15
16	PHARMACY	200105	4964	8209	53262	323		25099		16
17	MEDICAL RECORDS & LIBRARY	205694	7808	12912	49343	1293		2421		17
18	SOCIAL SERVICE	46611	1389	2298	12665	323		512		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1334336	80134	132502	382243	1293		5211	36181	25
35	NURSING FACILITY	1623099			391731	3555		5443		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	161856	21211	35074	42473	1293		5146	1772	37
40	ANESTHESIOLOGY	252364	1107	1831	68634			1190	848	40
41	RADIOLOGY-DIAGNOSTIC	552343	16348	27032	90434	969		1932	17931	41
44	LABORATORY	784569	11029	18237	103358	646		23369	21164	44
49	RESPIRATORY THERAPY	159871	5189	8580	40997	646		1209	19746	49
50	PHYSICAL THERAPY	416061	9610	15891	80795	646		653	5128	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									62
53	ELECTROCARDIOLOGY	4097						102	1558	53
55	MEDICAL SUPPLIES CHARGED TO PAT	61529							650	55
56	DRUGS CHARGED TO PATIENTS	321110							33295	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	662078	9806	16214	66191	646		5264	242	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	474497	40569	67084	127019	2908		2150	3024	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY	325835			68136	1293		548		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	12851592	322729	533654	1977937	25205	104306	88822	141539	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	68738	6202	10255		1616				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	12920330	328931	543909	1977937	26821	104306	88822	141539	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	400591								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		960280	960280						6.06
8	OPERATION OF PLANT		668066	53640	721706					8
9	LAUNDRY & LINEN SERVICE		161227	12945	21203	195375				9
10	HOUSEKEEPING		164905	13240		5788	183933			10
11	DIETARY		105221	8448	14305	735	26495	155204		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		400840	32184	20072		1269		454365	14
15	CENTRAL SERVICES & SUPPLY		16403	1317	6077					15
16	PHARMACY		291962	23442	15215					16
17	MEDICAL RECORDS & LIBRARY		279471	22439	23931					17
18	SOCIAL SERVICE		63798	5122	4258					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	46004	2017904	162020	245590	24605	80015	155204	393863	25
35	NURSING FACILITY		2023828	162490		152895				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	12723	281548	22606	65007	1159	7298		25087	37
40	ANESTHESIOLOGY	5653	331627	26627	3393					40
41	RADIOLOGY-DIAGNOSTIC	81375	788364	63299	50102	1644	4760			41
44	LABORATORY	97554	1059926	85103	33801		14279			44
49	RESPIRATORY THERAPY	22399	258637	20766	15902					49
50	PHYSICAL THERAPY	23939	552723	44379	29454	4796	12692			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	7728	13485	1083						53
55	MEDICAL SUPPLIES CHARGED TO PAT	6174	68353	5488						55
56	DRUGS CHARGED TO PATIENTS	52393	406798	32662						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	34826	795267	63853	30053	3753	22846		35425	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	9823	727074	58377	124336		14279			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY		395812	31780						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	400591	12833519	953310	702699	195375	183933	155204	454365	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		86811	6970	19007					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	400591	12920330	960280	721706	195375	183933	155204	454365	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 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	23797							15
16	PHARMACY		330619						16
17	MEDICAL RECORDS & LIBRARY			325841					17
18	SOCIAL SERVICE				73178				18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS			158743	15604	3253538		3253538	25
35	NURSING FACILITY					2339213		2339213	35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM					402705		402705	37
40	ANESTHESIOLOGY					361647		361647	40
41	RADIOLOGY-DIAGNOSTIC			80243		988412		988412	41
44	LABORATORY			36964		1230073		1230073	44
49	RESPIRATORY THERAPY					295305		295305	49
50	PHYSICAL THERAPY				6995	651039		651039	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY					14568		14568	53
55	MEDICAL SUPPLIES CHARGED TO PAT	23797				97638		97638	55
56	DRUGS CHARGED TO PATIENTS		326732			766192		766192	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY			49891	29863	1030951		1030951	61
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RURAL HEALTH CLINIC		3887		15335	943288		943288	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY				5381	432973		432973	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	23797	330619	325841	73178	12807542		12807542	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES					112788		112788	98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	23797	330619	325841	73178	12920330		12920330	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	NONPATIENT TELEPHONES 6.01	DATA PROCESSING 6.02	PURCHASING, RECEIVING AND STORAGE 6.03	ADMITTING 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		289	479	768	768				6.01
6.02	DATA PROCESSING		926	1532	2458	9	2467			6.02
6.03	PURCHASING RECEIVING AND STORES		11847	19589	31436	19		31455		6.03
6.04	ADMITTING		854	1412	2266				2266	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE		4168	6893	11061	28	2001			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		34910	57726	92636	127	466	1512		6.06
8	OPERATION OF PLANT		40453	66892	107345	19		930		8
9	LAUNDRY & LINEN SERVICE		6918	11440	18358	9		41		9
10	HOUSEKEEPING							413		10
11	DIETARY		4668	7718	12386	19		47		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		6549	10830	17379	37		23		14
15	CENTRAL SERVICES & SUPPLY		1983	3279	5262			70		15
16	PHARMACY		4964	8209	13173	9		8890		16
17	MEDICAL RECORDS & LIBRARY		7808	12912	20720	37		857		17
18	SOCIAL SERVICE		1389	2298	3687	9		181		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		80134	132502	212636	37		1845	580	25
35	NURSING FACILITY					102		1928		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		21211	35074	56285	37		1822	28	37
40	ANESTHESIOLOGY		1107	1831	2938			422	14	40
41	RADIOLOGY-DIAGNOSTIC		16348	27032	43380	28		684	287	41
44	LABORATORY		11029	18237	29266	19		8276	339	44
49	RESPIRATORY THERAPY		5189	8580	13769	19		428	316	49
50	PHYSICAL THERAPY		9610	15891	25501	19		231	82	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY							36	25	53
55	MEDICAL SUPPLIES CHARGED TO PAT								10	55
56	DRUGS CHARGED TO PATIENTS								533	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		9806	16214	26020	19		1864	4	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC		40569	67084	107653	83		761	46	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY					37		194		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		322729	533654	856383	722	2467	31455	2266	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		6202	10255	16457	46				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		328931	543909	872840	768	2467	31455	2266	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	13090								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		94741							6.06
8	OPERATION OF PLANT		5292	113586						8
9	LAUNDRY & LINEN SERVICE		1277	3337	23022					9
10	HOUSEKEEPING		1306		682	2401				10
11	DIETARY		833	2251	87	346	15969			11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		3175	3159		17		23790		14
15	CENTRAL SERVICES & SUPPLY		130	956					6418	15
16	PHARMACY		2313	2395						16
17	MEDICAL RECORDS & LIBRARY		2214	3766						17
18	SOCIAL SERVICE		505	670						18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1504	15984	38653	2899	1045	15969	20621		25
35	NURSING FACILITY		16036		18016					35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	416	2230	10231	137	95		1314		37
40	ANESTHESIOLOGY	185	2627	534						40
41	RADIOLOGY-DIAGNOSTIC	2661	6245	7885	194	62				41
44	LABORATORY	3181	8396	5320		186				44
49	RESPIRATORY THERAPY	732	2049	2503						49
50	PHYSICAL THERAPY	783	4378	4636	565	166				50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	253	107							53
55	MEDICAL SUPPLIES CHARGED TO PAT	202	541						6418	55
56	DRUGS CHARGED TO PATIENTS	1713	3222							56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1139	6299	4730	442	298		1855		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	321	5759	19569		186				63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY		3135							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	13090	94053	110595	23022	2401	15969	23790	6418	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		688	2991						98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	13090	94741	113586	23022	2401	15969	23790	6418	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 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	26780						16
17	MEDICAL RECORDS & LIBRARY		27594					17
18	SOCIAL SERVICE			5052				18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS		13444	1077	326294		326294	25
35	NURSING FACILITY				36082		36082	35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM				72595		72595	37
40	ANESTHESIOLOGY				6720		6720	40
41	RADIOLOGY-DIAGNOSTIC		6795		68221		68221	41
44	LABORATORY		3130		58113		58113	44
49	RESPIRATORY THERAPY				19816		19816	49
50	PHYSICAL THERAPY			483	36844		36844	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY				421		421	53
55	MEDICAL SUPPLIES CHARGED TO PAT				7171		7171	55
56	DRUGS CHARGED TO PATIENTS	26465			31933		31933	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY		4225	2062	48957		48957	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	315		1059	135754		135754	63.50
	OTHER REIMBURSABLE COST CENTERS							
71	HOME HEALTH AGENCY			371	3737		3737	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	26780	27594	5052	852658		852658	95
	NONREIMBURSABLE COST CENTERS							
98	PHYSICIANS' PRIVATE OFFICES				20182		20182	98
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	26780	27594	5052	872840		872840	103

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT SQUARE FEET 4	EMPLOYEE BENEFITS GROSS SALARIES 5	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	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	45453							3
4	NEW CAP REL COSTS-MVBLE EQUIP		45453						4
5	EMPLOYEE BENEFITS			6491132					5
6.01	NONPATIENT TELEPHONES	40	40		83				6.01
6.02	DATA PROCESSING	128	128	66171	1	249			6.02
6.03	PURCHASING RECEIVING AND STOR	1637	1637	41023	2		1289182		6.03
6.04	ADMITTING	118	118	62705				6369153	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABL	576	576	125597	3	202			6.05
6.06	OTHER ADMINISTRATIVE AND GENE	4824	4824	387713	14	47	61958		6.06
8	OPERATION OF PLANT	5590	5590	152653	2		38107		8
9	LAUNDRY & LINEN SERVICE	956	956	80699	1		1675		9
10	HOUSEKEEPING			107923			16932		10
11	DIETARY	645	645	13637	2		1916		11
12	CAFETERIA								12
14	NURSING ADMINISTRATION	905	905	276739	4		961		14
15	CENTRAL SERVICES & SUPPLY	274	274				2886		15
16	PHARMACY	686	686	174793	1		364306		16
17	MEDICAL RECORDS & LIBRARY	1079	1079	161931	4		35128		17
18	SOCIAL SERVICE	192	192	41563	1		7429		18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	11073	11073	1254433	4		75634	1628245	25
35	NURSING FACILITY			1285574	11		79007		35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	2931	2931	139387	4		74685	79759	37
40	ANESTHESIOLOGY	153	153	225242			17278	38170	40
41	RADIOLOGY-DIAGNOSTIC	2259	2259	296783	3		28042	806888	41
44	LABORATORY	1524	1524	339198	2		339184	952329	44
49	RESPIRATORY THERAPY	717	717	134541	2		17545	888524	49
50	PHYSICAL THERAPY	1328	1328	265151	2		9471	230735	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY						1475	70090	53
55	MEDICAL SUPPLIES CHARGED TO P							29260	55
56	DRUGS CHARGED TO PATIENTS							1498211	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	1355	1355	217223	2		76396	10877	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC	5606	5606	416846	9		31209	136065	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY			223607	4		7948		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	44596	44596	6491132	78	249	1289182	6369153	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES	857	857		5				98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	328931	543909	1977937	26821	104306	88822	141539	103
104	UNIT COST MULT-WS B PT I		11.966405		323.144578		.068898		104
104	UNIT COST MULT-WS B PT I	7.236728		.304714		418.899598		.022223	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				768	2497	31455	2266	107
108	UNIT COST MULT-WS B PT III				9.253012		.024399		108
108	UNIT COST MULT-WS B PT III					9.907631		.000356	108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES 6.05	RECON-CILIATION 6A.06	OTHER ADMINISTRATIVE AND GENER ACCUM COST 6.06	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING HOURS OF SERVICE 10	DIETARY MEALS SERVED 11	NURSING ADMINIS-TRATION HOURS OF SERVICE 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	19346812								6.05
6.06	OTHER ADMINISTRATIVE AND GENE		-960280	11960050						6.06
8	OPERATION OF PLANT			668066	32540					8
9	LAUNDRY & LINEN SERVICE			161227	956	756615				9
10	HOUSEKEEPING			164905		22416	6956			10
11	DIETARY			105221	645	2846	1002	13196		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION			400840	905		48		96787	14
15	CENTRAL SERVICES & SUPPLY			16403	274					15
16	PHARMACY			291962	686					16
17	MEDICAL RECORDS & LIBRARY			279471	1079					17
18	SOCIAL SERVICE			63798	192					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	2221786		2017904	11073	95287	3026	13196	83897	25
35	NURSING FACILITY			2023828		592104				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	614456		281548	2931	4488	276		5344	37
40	ANESTHESIOLOGY	273020		331627	153					40
41	RADIOLOGY-DIAGNOSTIC	3930012		788364	2259	6367	180			41
44	LABORATORY	4711554		1059926	1524		540			44
49	RESPIRATORY THERAPY	1081761		258637	717					49
50	PHYSICAL THERAPY	1156152		552723	1328	18574	480			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	373210		13485						53
55	MEDICAL SUPPLIES CHARGED TO P	298166		68353						55
56	DRUGS CHARGED TO PATIENTS	2530339		406798						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1681935		795267	1355	14533	864		7546	61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RURAL HEALTH CLINIC	474421		727074	5606		540			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY			395812						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	19346812	-960280	11873239	31683	756615	6956	13196	96787	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES			86811	857					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	400591		960280	721706	195375	183933	155204	454365	103
104	UNIT COST MULT-WS B PT I	.020706		.080291		.258222		11.761443		104
104	UNIT COST MULT-WS B PT I				22.179041		26.442352		4.694484	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	13090		94741	113586	23022	2401	15969	23790	107
108	UNIT COST MULT-WS B PT III	.000677		.007921		.030428		1.210139		108
108	UNIT COST MULT-WS B PT III				3.490658		.345170		.245797	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	57796				15
16	PHARMACY		368827			16
17	MEDICAL RECORDS & LIBRARY			68008		17
18	SOCIAL SERVICE				8160	18
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS			33132	1740	25
35	NURSING FACILITY					35
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM					37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC			16748		41
44	LABORATORY			7715		44
49	RESPIRATORY THERAPY					49
50	PHYSICAL THERAPY				780	50
51	OCCUPATIONAL THERAPY					51
52	SPEECH PATHOLOGY					52
53	ELECTROCARDIOLOGY					53
55	MEDICAL SUPPLIES CHARGED TO P	57796				55
56	DRUGS CHARGED TO PATIENTS		364491			56
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY			10413	3330	61
62	OBSERVATION BEDS (NON-DISTINC					62
63.50	RURAL HEALTH CLINIC		4336		1710	63.50
	OTHER REIMBURSABLE COST CENTERS					
71	HOME HEALTH AGENCY				600	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	57796	368827	68008	8160	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	23797	330619	325841	73178	103
104	UNIT COST MULT-WS B PT I	.411741		4.791216		104
104	UNIT COST MULT-WS B PT I		.896407		8.967892	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	6418	26780	27594	5052	107
108	UNIT COST MULT-WS B PT III	.111046		.405746		108
108	UNIT COST MULT-WS B PT III		.072609		.619118	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	3253538		3253538		3253538	25
35	NURSING FACILITY	2339213		2339213		2339213	35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	402705		402705		402705	37
40	ANESTHESIOLOGY	361647		361647		361647	40
41	RADIOLOGY-DIAGNOSTIC	988412		988412		988412	41
44	LABORATORY	1230073		1230073		1230073	44
49	RESPIRATORY THERAPY	295305		295305		295305	49
50	PHYSICAL THERAPY	651039		651039		651039	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	14568		14568		14568	53
55	MEDICAL SUPPLIES CHARGED TO	97638		97638		97638	55
56	DRUGS CHARGED TO PATIENTS	766192		766192		766192	56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1030951		1030951		1030951	61
62	OBSERVATION BEDS (NON-DISTI	562367		562367		562367	62
63.50	RURAL HEALTH CLINIC	943288		943288		943288	63.50
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	12936936		12936936		12936936	101
102	LESS OBSERVATION BEDS	562367		562367		562367	102
103	TOTAL	12374569		12374569		12374569	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	1628245		1628245				25
35	NURSING FACILITY	1759964		1759964				35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	41372	371073	412445	.976385	.976385	.976385	37
40	ANESTHESIOLOGY	45865	221747	267612	1.351386	1.351386	1.351386	40
41	RADIOLOGY-DIAGNOSTIC	784343	3056104	3840447	.257369	.257369	.257369	41
44	LABORATORY	952329	3759225	4711554	.261076	.261076	.261076	44
49	RESPIRATORY THERAPY	431285	106540	537825	.549073	.549073	.549073	49
50	PHYSICAL THERAPY	230121	924481	1154602	.563864	.563864	.563864	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	81090	292120	373210	.039034	.039034	.039034	53
55	MEDICAL SUPPLIES CHARGED TO	629290	521007	1150297	.084881	.084881	.084881	55
56	DRUGS CHARGED TO PATIENTS	1498211	1032128	2530339	.302802	.302802	.302802	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	4937	1676998	1681935	.612955	.612955	.612955	61
62	OBSERVATION BEDS (NON-DISTI	600	547978	548578	1.025136	1.025136	1.025136	62
63.50	RURAL HEALTH CLINIC	136065	338356	474421	1.988293	1.988293	1.988293	63.50
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	8223717	12847757	21071474				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	8223717	12847757	21071474				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	.976385	.976385	.976385				37
40	ANESTHESIOLOGY	1.351386	1.351386	1.351386				40
41	RADIOLOGY-DIAGNOSTIC	.257369	.257369	.257369				41
44	LABORATORY	.261076	.261076	.261076				44
49	RESPIRATORY THERAPY	.549073	.549073	.549073				49
50	PHYSICAL THERAPY	.563864	.563864	.563864				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.039034	.039034	.039034				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.084881	.084881	.084881				55
56	DRUGS CHARGED TO PATIENTS	.302802	.302802	.302802				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.612955	.612955	.612955				61
62	OBSERVATION BEDS (NON-DISTINCT	1.025136	1.025136	1.025136				62
63.50	RURAL HEALTH CLINIC	1.988293	1.988293	1.988293				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	.302802	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] TITLE XVIII-PT B
[ ] TITLE XIX - O/P

[XX] HOSPITAL (14-1326)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] 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	189782								37
40	ANESTHESIOLOGY	61173								40
41	RADIOLOGY-DIAGNOSTIC	1000850								41
44	LABORATORY	1569093								44
49	RESPIRATORY THERAPY	67428								49
50	PHYSICAL THERAPY	382052								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	174278								53
55	MEDICAL SUPPLIES CHARGED TO PA	222491								55
56	DRUGS CHARGED TO PATIENTS	458056								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	624886								61
62	OBSERVATION BEDS (NON-DISTINCT	246993								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	4997082								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	4997082								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	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 COST ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	185300							37
40	ANESTHESIOLOGY	82668							40
41	RADIOLOGY-DIAGNOSTIC	257588							41
44	LABORATORY	409653							44
49	RESPIRATORY THERAPY	37023							49
50	PHYSICAL THERAPY	215425							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	6803							53
55	MEDICAL SUPPLIES CHARGED TO PAT	18885							55
56	DRUGS CHARGED TO PATIENTS	138700							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	383027							61
62	OBSERVATION BEDS (NON-DISTINCT	253201							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	1988273							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1988273							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				326294	54194	272100	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				326294		272100	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	3850	339			70.68	23961	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	3850	339				23961	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		72595	412445	20708			.176011	3645	37
40	ANESTHESIOLOGY		6720	267612	24177			.025111	607	40
41	RADIOLOGY-DIAGNOSTIC		68221	3840447	78685			.017764	1398	41
44	LABORATORY		58113	4711554	88473			.012334	1091	44
49	RESPIRATORY THERAPY		19816	537825	31181			.036845	1149	49
50	PHYSICAL THERAPY		36844	1154602	6192			.031911	198	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		421	373210	18442			.001128	21	53
55	MEDICAL SUPPLIES CHARGED TO P		7171	1150297	133310			.006234	831	55
56	DRUGS CHARGED TO PATIENTS		31933	2530339	105226			.012620	1328	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		48957	1681935				.029108		61
62	OBSERVATION BEDS (NON-DISTINC			548578						62
63.50	RURAL HEALTH CLINIC			474421						63.50
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		350791	17208844	506394				10268	101

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES

[ ] TITLE V - O/P
[ ] TITLE XVIII-PT B
[XX] TITLE XIX - O/P

[XX] HOSPITAL (14-1326)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8 1	PART I COL. 9 1.01	PART II COL. 9 1.02	PROGRAM CHARGES: OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.976385	.976385	.976385				37
40	ANESTHESIOLOGY	1.351386	1.351386	1.351386				40
41	RADIOLOGY-DIAGNOSTIC	.257369	.257369	.257369				41
44	LABORATORY	.261076	.261076	.261076				44
49	RESPIRATORY THERAPY	.549073	.549073	.549073				49
50	PHYSICAL THERAPY	.563864	.563864	.563864				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.039034	.039034	.039034				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.084881	.084881	.084881				55
56	DRUGS CHARGED TO PATIENTS	.302802	.302802	.302802				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.612955	.612955	.612955				61
62	OBSERVATION BEDS (NON-DISTINCT	1.025136	1.025136	1.025136				62
63.50	RURAL HEALTH CLINIC	1.988293	1.988293	1.988293				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	.302802	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
	[ ]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
	[XX]	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	48623								37
40	ANESTHESIOLOGY	55613								40
41	RADIOLOGY-DIAGNOSTIC	821552								41
44	LABORATORY	982167								44
49	RESPIRATORY THERAPY	27992								49
50	PHYSICAL THERAPY	180767								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	88944								53
55	MEDICAL SUPPLIES CHARGED TO PA	219028								55
56	DRUGS CHARGED TO PATIENTS	189257								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	499673								61
62	OBSERVATION BEDS (NON-DISTINCT	166476								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	3280092								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	3280092								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	SNF
[ ]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
[XX]	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) 9	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.01) 9.01	PROGRAM COST: ALL OTHER (COLUMNS 1.01x5.02) 9.02	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.03 9.03	PROGRAM COST: PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	47475							37
40	ANESTHESIOLOGY	75155							40
41	RADIOLOGY-DIAGNOSTIC	211442							41
44	LABORATORY	256420							44
49	RESPIRATORY THERAPY	15370							49
50	PHYSICAL THERAPY	101928							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	3472							53
55	MEDICAL SUPPLIES CHARGED TO PAT	18591							55
56	DRUGS CHARGED TO PATIENTS	57307							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	306277							61
62	OBSERVATION BEDS (NON-DISTINCT	170661							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	1264098							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1264098							104

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)	4740						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3850						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3850						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	371						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	372						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	73						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	74						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2403						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	371						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	372						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	112.36						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	115.73						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3253538						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	8202						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	8564						25
26 TOTAL SWING-BED COST	540373						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2713165						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1427295						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1427295						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.900914						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	370.73						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	2713165						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	704.72					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1693442					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1693442					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	906306					48
49	TOTAL PROGRAM INPATIENT COSTS	2599748					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1326)	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	261451	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	262156	61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	523607	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	798					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	704.72					84
85 OBSERVATION BED COST	562367					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

	INPATIENT DAYS	HOSPITAL (PPS) (14-1326) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	NF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4740						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3850						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3850						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	371						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	372						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	73						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	74						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	339						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	112.36						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	115.73						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3253538						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	8202						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	8564						25
26 TOTAL SWING-BED COST	540373						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2713165						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1427295						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1427295						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.900914						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	370.73						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	2713165						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	704.72					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	238900					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	238900					41

		TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
		1	2	3	4	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	160750					48
49	TOTAL PROGRAM INPATIENT COSTS	399650					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	23961					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	10268					51
52	TOTAL PROGRAM EXCLUDABLE COST	34229					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	365421					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

		HOSPITAL (PPS) (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		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	798					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	704.72					84
85 OBSERVATION BED COST	562367					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	2713165		562367		86
87	NEW CAPITAL-RELATED COST	2713165		562367		87
88	NON PHYSICIAN ANESTHETIST	2713165		562367		88
89	MEDICAL EDUCATION	2713165		562367		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		1159270		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.976385	19687	19222	37
40	ANESTHESIOLOGY	1.351386	21408	28930	40
41	RADIOLOGY-DIAGNOSTIC	.257369	473064	121752	41
44	LABORATORY	.261076	691948	180651	44
49	RESPIRATORY THERAPY	.549073	330593	181520	49
50	PHYSICAL THERAPY	.563864	103559	58393	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.039034	52800	2061	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.084881	402269	34145	55
56	DRUGS CHARGED TO PATIENTS	.302802	920056	278595	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.612955	1691	1037	61
62	OBSERVATION BEDS (NON-DISTINCT	1.025136			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.988293			63.50
101	TOTAL		3017075	906306	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		3017075		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	.976385	909	888	37
40	ANESTHESIOLOGY	1.351386	223	301	40
41	RADIOLOGY-DIAGNOSTIC	.257369	52613	13541	41
44	LABORATORY	.261076	76520	19978	44
49	RESPIRATORY THERAPY	.549073	49164	26995	49
50	PHYSICAL THERAPY	.563864	85592	48282	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.039034	9610	375	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.084881	66850	5674	55
56	DRUGS CHARGED TO PATIENTS	.302802	244747	74110	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.612955			61
62	OBSERVATION BEDS (NON-DISTINCT	1.025136	506	519	62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.988293			63.50
101	TOTAL		586734	190643	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		586734		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V
[ ] TITLE XVIII-PT A
[XX] TITLE XIX

[XX] HOSPITAL (14-1326)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[ ] S/B-SNF
[ ] S/B-NF
[ ] ICF/MR

[XX] PPS
[ ] TEFRA
[ ] OTHER

	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		158950		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.976385	20708	20219	37
40	ANESTHESIOLOGY	1.351386	24177	32672	40
41	RADIOLOGY-DIAGNOSTIC	.257369	78685	20251	41
44	LABORATORY	.261076	88473	23098	44
49	RESPIRATORY THERAPY	.549073	31181	17121	49
50	PHYSICAL THERAPY	.563864	6192	3491	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.039034	18442	720	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.084881	133310	11315	55
56	DRUGS CHARGED TO PATIENTS	.302802	105226	31863	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.612955			61
62	OBSERVATION BEDS (NON-DISTINCT	1.025136			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.988293			63.50
101	TOTAL		506394	160750	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		506394		103

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	1988273			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	1988273			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	2008156			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	31841			18
18.01	COINSURANCE	683664			18.01
19	SUBTOTAL	1292651			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	1292651			23
24	PRIMARY PAYER PAYMENTS	31			24
25	SUBTOTAL	1292620			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	196300			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	196300			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	196300			27.02
28	SUBTOTAL	1488920			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	1488920			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1359116			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	129804			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15 II, SECTION 115.2				36

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				1906601		1408680	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	01/23/2009	23534			3.01
	PROGRAM	.02					3.02
	TO	.03				NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50			01/23/2009	49564	3.50
	PROVIDER	.51					3.51
	TO	.52		NONE			3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99		23534		-49564	3.99
4 TOTAL INTERIM PAYMENTS				1930135		1359116	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		302485		129804	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				2232620		1488920	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				634614			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	01/23/2009	2482			3.50
	PROVIDER	.51	06/19/2009	36420			3.51
	TO	.52				NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99		-38902			3.99
4 TOTAL INTERIM PAYMENTS				595712			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		105141			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				700853			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		528843				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		192549				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		743				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		721392				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		721392				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		721392				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		20539				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		700853				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		700853				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		595712				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		105141				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	2599748						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	2599748						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2625745						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	2625745						19
20	DEDUCTIBLES	487545						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	2138200						22
23	COINSURANCE	12442						23
24	SUBTOTAL	2125758						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	106862						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	106862						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	106862						25.02
26	SUBTOTAL	2232620						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	2232620						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1930135						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	302485						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

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

WORKSHEET E-3
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	1264098						2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	1264098						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	1264098						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES	3786486						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	1264098						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	1264098						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
PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3
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	2037325				1
2	TEMPORARY INVESTMENTS	504536				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2760921				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-804000				6
7	INVENTORY	425566				7
8	PREPAID EXPENSES	184215				8
9	OTHER CURRENT ASSETS	300000				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	5408563				11
	FIXED ASSETS					
12	LAND	74449				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	607332				13
13.01	ACCUMULATED DEPRECIATION	-209503				13.01
14	BUILDINGS	18374558				14
14.01	ACCUMULATED DEPRECIATION	-3581461				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	5323969				18
18.01	ACCUMULATED DEPRECIATION	-3569179				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	17020165				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	7216059		103823		25
26	TOTAL OTHER ASSETS	7216059		103823		26
27	TOTAL ASSETS	29644787		103823		27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1408452				28
29	SALARIES, WAGES & FEES PAYABLE	690449				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	458198				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	130803				35
36	TOTAL CURRENT LIABILITIES	2687902				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	18368031				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	2304000				41
42	TOTAL LONG TERM LIABILITIES	20672031				42
43	TOTAL LIABILITIES	23359933				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	6284854				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			103823		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	6284854		103823		51
52	TOTAL LIABILITIES AND FUND BALANCES	29644787		103823		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	7392558		100758		1
2	NET INCOME (LOSS)	-1107704				2
3	TOTAL	6284854		100758		3
4	ADDITIONS (CREDIT ADJUSTMENTS)			3065		4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS			3065		10
11	SUBTOTAL	6284854		103823		11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	6284854		103823		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	1427295		1427295	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	132150		132150	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	1559445		1559445	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	1559445		1559445	16
17	ANCILLARY SERVICES	4662766	10419856	15082622	17
18	OUTPATIENT SERVICES	91529	3182212	3273741	18
18.50	RURAL HEALTH CLINIC	136065	338356	474421	18.50
19	HOME HEALTH AGENCY		237663	237663	19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24	OTHER	1746949		1746949	24
25	TOTAL PATIENT REVENUES	8196754	14178087	22374841	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		13567324	26
27	BAD DEBTS	1255431		27
28	LOSS ON SWAP CONTRACT	1372000		28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		2627431	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		16194755	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	22374841	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	8347634	2
3	NET PATIENT REVENUES	14027207	3
4	LESS - TOTAL OPERATING EXPENSES	16194755	4
5	NET INCOME FROM SERVICE TO PATIENTS	-2167548	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	426159	6
7	INCOME FROM INVESTMENTS	36010	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	239	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	10347	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	35824	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	414473	23
24	OTHER	136792	24
25	TOTAL OTHER INCOME	1059844	25
26	TOTAL	-1107704	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-1107704	31

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

		SALARIES 1	EMPLOYEE BENEFITS 2	TRANS-PORTATION 3	CONTRACTED/ PURCH SVCS 4	OTHER COSTS 5	TOTAL HHA COST 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	77275				42287	119562	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	100617				17103	117720	6
7	PHYSICAL THERAPY	44566			4440	5117	54123	7
8	OCCUPATIONAL THERAPY				27608		27608	8
9	SPEECH PATHOLOGY				1352		1352	9
10	MEDICAL SOCIAL SERVICES					300	300	10
11	HOME HEALTH AIDE	1150					1150	11
12	SUPPLIES					4020	4020	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	223608			33400	68827	325835	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		119562		119562	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		117720		117720	6
7	PHYSICAL THERAPY		54123		54123	7
8	OCCUPATIONAL THERAPY		27608		27608	8
9	SPEECH PATHOLOGY		1352		1352	9
10	MEDICAL SOCIAL SERVICES		300		300	10
11	HOME HEALTH AIDE		1150		1150	11
12	SUPPLIES		4020		4020	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		325835		325835	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	119562					119562	119562		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	117720					117720	68234	185954	6
7	PHYSICAL THERAPY	54123					54123	31371	85494	7
8	OCCUPATIONAL THERAPY	27608					27608	16002	43610	8
9	SPEECH PATHOLOGY	1352					1352	784	2136	9
10	MEDICAL SOCIAL SERVICES	300					300	174	474	10
11	HOME HEALTH AIDE	1150					1150	667	1817	11
12	SUPPLIES	4020					4020	2330	6350	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	325835					325835		325835	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) 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					-119562	206273	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						117720	6
7	PHYSICAL THERAPY						54123	7
8	OCCUPATIONAL THERAPY						27608	8
9	SPEECH PATHOLOGY						1352	9
10	MEDICAL SOCIAL SERVICES						300	10
11	HOME HEALTH AIDE						1150	11
12	SUPPLIES						4020	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					-119562	206273	24
25	COST TO BE ALLOC (PER W/S H)						119562	25
26	UNIT COST MULTIPLIER						.579630	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				23546	1293		548		1
2	SKILLED NURSING CARE	185954			30660					2
3	PHYSICAL THERAPY	85494			13580					3
4	OCCUPATIONAL THERAPY	43610								4
5	SPEECH PATHOLOGY	2136								5
6	MEDICAL SOCIAL SERVICES	474								6
7	HOME HEALTH AIDE	1817			350					7
8	SUPPLIES	6350								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	325835			68136	1293		548		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 6.05	SUBTOTAL 5A	OTHER ADMI NISTRATIVE AND GENER 6.06	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	
1	ADMINISTRATIVE AND GENERAL		25387	2038						1
2	SKILLED NURSING CARE		216614	17392						2
3	PHYSICAL THERAPY		99074	7955						3
4	OCCUPATIONAL THERAPY		43610	3501						4
5	SPEECH PATHOLOGY		2136	172						5
6	MEDICAL SOCIAL SERVICES		474	38						6
7	HOME HEALTH AIDE		2167	174						7
8	SUPPLIES		6350	510						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		395812	31780						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 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	SUBTOTAL 27	
1	ADMINISTRATIVE AND GENERAL					5381	32806		32806	1
2	SKILLED NURSING CARE						234006		234006	2
3	PHYSICAL THERAPY						107029		107029	3
4	OCCUPATIONAL THERAPY						47111		47111	4
5	SPEECH PATHOLOGY						2308		2308	5
6	MEDICAL SOCIAL SERVICES						512		512	6
7	HOME HEALTH AIDE						2341		2341	7
8	SUPPLIES						6860		6860	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					5381	432973		432973	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	19185	253191	2
3	PHYSICAL THERAPY	8774	115803	3
4	OCCUPATIONAL THERAPY	3862	50973	4
5	SPEECH PATHOLOGY	189	2497	5
6	MEDICAL SOCIAL SERVICES	42	554	6
7	HOME HEALTH AIDE	192	2533	7
8	SUPPLIES	562	7422	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	32806	432973	20
21	UNIT COST MULTIPLIER	.081981		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 STORAGE COSTS SUPPLIES 6.03	ADMITTING INPATIENT CHARGES 6.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS CHARGES 6.05	
1	ADMINISTRATIVE AND GENERAL			77274	4		7948			1
2	SKILLED NURSING CARE			100617						2
3	PHYSICAL THERAPY			44566						3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE			1150						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			223607	4		7948			20
21	TOTAL COST TO BE ALLOCATED			68136	1293		548			21
22	UNIT COST MULTIPLIER			.304713						22
22	UNIT COST MULTIPLIER				323.250000		.068948			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 ADMI NISTRATIVE 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		25387							1
2	SKILLED NURSING CARE		216614							2
3	PHYSICAL THERAPY		99074							3
4	OCCUPATIONAL THERAPY		43610							4
5	SPEECH PATHOLOGY		2136							5
6	MEDICAL SOCIAL SERVICES		474							6
7	HOME HEALTH AIDE		2167							7
8	SUPPLIES		6350							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		395812							20
21	TOTAL COST TO BE ALLOCATED		31780							21
22	UNIT COST MULTIPLIER									22
22	UNIT COST MULTIPLIER		.080291							22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
STATISTICAL BASIS

HHA NO.: 14-7167

WORKSHEET H-5
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				600	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				600	20
21	TOTAL COST TO BE ALLOCATED				5381	21
22	UNIT COST MULTIPLIER					22
22	UNIT COST MULTIPLIER				8.968333	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	253191		253191	850	297.87	1
2	PHYSICAL THERAPY	3	115803		115803	801	144.57	2
3	OCCUPATIONAL THERAPY	4	50973		50973	416	122.53	3
4	SPEECH PATHOLOGY	5	2497		2497	30	83.23	4
5	MEDICAL SOCIAL SERV	6	554		554			5
6	HOME HEALTH AIDE SERV	7	2533		2533	33	76.76	6
7	TOTAL		425551		425551	2130		7

LIMITATION COST COMPUTATION

	PATIENT SERVICES	MSA NO.				PROGRAM COST LIMITS	
		1	2	3	4	5	
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	7422		7422	4386	1.692202	15
16	COST OF DRUGS	9						16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20

PER BENEFICIARY COST LIMITATION:

		MSA NO. 1	AMOUNT 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			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL PROGRAM COST	
	6	7	8	9	10	11	12	
1 SKILLED NURSING CARE	458	207		136424	61659		198083	1
2 PHYSICAL THERAPY	472	209		68237	30215		98452	2
3 OCCUPATIONAL THERAPY	229	134		28059	16419		44478	3
4 SPEECH PATHOLOGY	30			2497			2497	4
5 MEDICAL SOCIAL SERV								5
6 HOME HEALTH AIDE SERV	33			2533			2533	6
7 TOTAL	1222	550		237750	108293		346043	7

LIMITATION COST COMPUTATION	PROGRAM VISITS			COST OF SERVICES				
		PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	TOTAL 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	1924	1735			3256	2936			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	.563864			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	.084881			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	56	.302802			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 1	COST PER VISIT 2	PRIOR TO 1/1/98 2.01	FROM 1/1/98 THRU 12/31/98 3	PRIOR TO 1/1/98 3.01	FROM 1/1/98 THRU 12/31/98 4	VISITS ON OR AFTER 1/1/99 5	
1	PHYSICAL THERAPY	2	144.57						1
2	OCCUPATIONAL THERAPY	3	122.53						2
3	SPEECH PATHOLOGY	4	83.23						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 1	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE 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	228014	109848	10.01
10.02	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03	TOTAL PPS REIMBURSEMENT - LUPA EPISODES		2701	10.03
10.04	TOTAL PPS REIMBURSEMENT - PEP EPISODES	183		10.04
10.05	TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.05
10.06	TOTAL PPS REIMBURSEMENT - SCIC EPISODES			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	228197	112549	12
13	EXCESS REASONABLE COST			13
14	SUBTOTAL	228197	112549	14
15	COINSURANCE BILLED TO PROGRAM PATIENTS			15
16	NET COST	228197	112549	16
17	REIMBURSABLE BAD DEBTS			17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	228197	112549	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	228197	112549	22
23	SEQUESTRATION ADJUSTMENT			23
24	SUBTOTAL	228197	112549	24
25	TOTAL INTERIM PAYMENTS	228197	112549	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				228197		112549	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				228197		112549	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				228197		112549	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

RHC I
COMPONENT NO: 14-3477

WORKSHEET M-1

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

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

	COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	172428		172428		172428		172428	1
2 PHYSICIAN ASSISTANT	86339		86339		86339		86339	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	38795		38795		38795		38795	9
10 SUBTOTAL (SUM OF LINES 1-9)	297562		297562		297562		297562	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		4336	4336		4336		4336	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)		4336	4336		4336		4336	21
22 TOTAL COSTS OF HEALTH CARE SERVICES	297562	4336	301898		301898		301898	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		6512	6512		6512		6512	29
30 ADMINISTRATIVE COSTS	108978	57109	166087		166087		166087	30
31 TOTAL FACILITY OVERHEAD	108978	63621	172599		172599		172599	31
32 TOTAL FACILITY COSTS	406540	67957	474497		474497		474497	32

RHC I
COMPONENT NO: 14-3477

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX: [XX] RHC
[ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1 PHYSICIANS	0.98	2390	4200	4116		1
2 PHYSICIAN ASSISTANTS	0.95	1788	2100	1995		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	1.93	4178		6111	6111	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	1.93	4178			6111	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES	301898	10
11 TOTAL NONREIMBURSABLE COSTS		11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)	301898	12
13 RATIO OF RHC/FQHC SERVICES	1.000000	13
14 TOTAL FACILITY OVERHEAD	172599	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	468791	15
16 TOTAL OVERHEAD	641390	16
17 ALLOWABLE GME OVERHEAD		17
18 SUBTRACT LINE 17 FROM LINE 16	641390	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	641390	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	943288	20

RHC I
COMPONENT NO: 14-3477

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

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	943288	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	7659	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	935629	3
4	TOTAL VISITS	6111	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	6111	6
7	ADJUSTED COST PER VISIT	153.11	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 3	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	153.11	153.11		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	693	694		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	106105	106258		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			212363	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			12281	17
18	NET PROGRAM COST EXCLUDING VACCINES			200082	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			160066	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			4801	20
21	TOTAL REIMBURSABLE PROGRAM COST			164867	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			164867	24
25	INTERIM PAYMENTS			127090	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			37777	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.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COSTS	297562	297562	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000060	0.001100	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	18	327	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	291	1815	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	309	2142	5
6	TOTAL DIRECT COST OF THE FACILITY	301898	301898	6
7	TOTAL OVERHEAD	641390	641390	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.001024	0.007095	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	657	4551	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	966	6693	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	10	191	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	96.60	35.04	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	4	126	13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	386	4415	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7659	15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		4801	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				107541	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	01/23/2009	19549	3.01
	PROGRAM TO PROVIDER	.02			3.02
		.03			3.03
		.04			3.04
		.05			3.05
		.50			3.50
	PROVIDER TO PROGRAM	.51			3.51
		.52		NONE	3.52
		.53			3.53
		.54			3.54
SUBTOTAL		.99		19549	3.99
4 TOTAL INTERIM PAYMENTS				127090	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01			5.01
		.02		NONE	5.02
		.03			5.03
		.50			5.50
	PROVIDER TO PROGRAM	.51		NONE	5.51
		.52			5.52
SUBTOTAL		.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		37777	6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				164867	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

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

	COST CENTERS	TITLE XVIII PART A 1	TITLE XVIII PART B 2	TITLE XIX INPATIENT 3	TITLE XIX OUTPATIENT 4	TITLE V INPATIENT 5	TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
25	ADULTS & PEDIATRICS	62.42		8.81				71.23	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	4.77	46.01	5.02	11.79			67.59	37
40	ANESTHESIOLOGY	8.00	22.86	9.03	20.78			60.67	40
41	RADIOLOGY-DIAGNOSTIC	12.32	26.06	2.05	21.39			61.82	41
44	LABORATORY	14.69	33.30	1.88	20.85			70.72	44
49	RESPIRATORY THERAPY	61.47	12.54	5.80	5.20			85.01	49
50	PHYSICAL THERAPY	8.97	33.09	0.54	15.66			58.26	50
53	ELECTROCARDIOLOGY	14.15	46.70	4.94	23.83			89.62	53
55	MEDICAL SUPPLIES CHARGED TO PAT	34.97	19.34	11.59	19.04			84.94	55
56	DRUGS CHARGED TO PATIENTS	36.36	18.10	4.16	7.48			66.10	56
61	EMERGENCY	0.10	37.15		29.71			66.96	61
62	OBSERVATION BEDS (NON-DISTINCT		45.02		30.35			75.37	62
101	TOTAL CHARGES	14.32	23.71	2.40	15.57			56.00	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT	328931	2.55	-328931	-5.75			3
4	NEW CAP REL COSTS-MVBLE EQUIP	543909	4.21	-543909	-9.51			4
5	EMPLOYEE BENEFITS	1977937	15.31	-1977937	-34.59			5
6.01	NONPATIENT TELEPHONES	26053	.20	-26053	-.46			6.01
6.02	DATA PROCESSING	81362	.63	-81362	-1.42			6.02
6.03	PURCHASING RECEIVING AND STORES	44240	.34	-44240	-.77			6.03
6.04	ADMITTING	120166	.93	-120166	-2.10			6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	265672	2.06	-265672	-4.65			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	721020	5.58	-721020	-12.61			6.06
8	OPERATION OF PLANT	510934	3.95	-510934	-8.94			8
9	LAUNDRY & LINEN SERVICE	117841	.91	-117841	-2.06			9
10	HOUSEKEEPING	130852	1.01	-130852	-2.29			10
11	DIETARY	87902	.68	-87902	-1.54			11
12	CAFETERIA							12
14	NURSING ADMINISTRATION	297776	2.30	-297776	-5.21			14
15	CENTRAL SERVICES & SUPPLY	10942	.08	-10942	-.19			15
16	PHARMACY	200105	1.55	-200105	-3.50			16
17	MEDICAL RECORDS & LIBRARY	205694	1.59	-205694	-3.60			17
18	SOCIAL SERVICE	46611	.36	-46611	-.82			18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1334336	10.33	1919202	33.56	3253538	25.18	25
35	NURSING FACILITY	1623099	12.56	716114	12.52	2339213	18.10	35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	161856	1.25	240849	4.21	402705	3.12	37
40	ANESTHESIOLOGY	252364	1.95	109283	1.91	361647	2.80	40
41	RADIOLOGY-DIAGNOSTIC	552343	4.27	436069	7.63	988412	7.65	41
44	LABORATORY	784569	6.07	445504	7.79	1230073	9.52	44
49	RESPIRATORY THERAPY	159871	1.24	135434	2.37	295305	2.29	49
50	PHYSICAL THERAPY	416061	3.22	234978	4.11	651039	5.04	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	4097	.03	10471	.18	14568	.11	53
55	MEDICAL SUPPLIES CHARGED TO PAT	61529	.48	36109	.63	97638	.76	55
56	DRUGS CHARGED TO PATIENTS	321110	2.49	445082	7.78	766192	5.93	56
61	EMERGENCY	662078	5.12	368873	6.45	1030951	7.98	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	474497	3.67	468791	8.20	943288	7.30	63.50
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY	325835	2.52	107138	1.87	432973	3.35	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	68738	.53	44050	.77	112788	.87	98

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	12920330	100.00	0	.00	12920330	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)	1772848
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)	4615030
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.384

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES	CLINIC NAME Hamilton Memorial Family Clinic	REPORTING PERIOD 14-3477 FROM: 7-1-08 TO: 6-30-09	ATTACHMENT #1

	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL COL.1&2 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE COL.3&4 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES COL.5&6 7
1	SUPPLEMENTAL COSTS							
2	Pharmacy	None						
3	Patient Transportation							
4	Medical Case Management							
5	Health Education							
6	Nutrition Counseling							
7	Others(specify)							
8								
9								
10								
11								
12	Supplemental Subtotal(sum of lines 2 through 11)							
13	DENTAL							
14	NON-ALLOWABLE COST CENTERS							
15	HM\HK Case Management							
16	WIC(Women,Infants, & Children)							
17	Fundraising & Public Relations							
18	Social Services							
19	Unlicensed Social Workers							
20	Others(specify)							
21								
22								
23								
24								
25	Non-Allowable Subtotal(sum of lines 15 - 24)							
26	Totals for schedule C (sum of lines 12,13, &25)							

NOTE This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

RURAL HEALTH CENTER
DENTAL STATISTICS

CLINIC NAME Hamilton Memorial Family Clinic

REPORTING PERIOD FROM 7-1-08 TO: 6-30-09

14-3477

ATTACHMENT #2

	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSI-FICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3&4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL.5&6) 7
1	RHC DENTAL STAFF COST							
2	Dentists	N/A						
3	Dental Hygienist							
4								
5								
6	TOTAL - Dentists(Sum of lines 1 through 5)							
7	Other - Dental Staff							
8								
9								
10								
11	SUBTOTAL- Other Dental Staff(Sum of lines 7-10)							
12	TOTAL - Dental Staff (Sum of lines 6 and 11)							
13	Dental Services Under Agreement							
14								
15	TOTAL DENTAL COST(Sum of lines 12 through 14)							

DENTAL SERVICES PERSONNEL,EQUIVALENTS,HOURS ON SITE, AND ENCOUNTERS

	DENTAL SERVICES PERSONNEL	FULL TIME PERSONNEL EQUIVALENTS (FTEs) 1	HEALTH SERVICES HOURS 2	ENCOUNTERS ON-SITE 3	OFF-SITE 4	TOTAL 5
16	RHC DENTAL STAFF N/A					
17	Dentists					
18	Dental Hygienist					
19						
20						
21	TOTAL - Dentists(Sum of lines 17 through 20)					
22	Other - Dental Staff					
23						
24						
25						
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)					
27	TOTAL - Dental Staff(Sum of lines 21 and 26)					
28	Dental Services Under Agreement					
29						
30	TOTAL DENTAL(Sum of lines 27 through 29)					

NOTE Total dental cost from line 15, column 7, must agree with Attachment #1, line 13