HAMILTON MEMORIAL HOSPITAL

MCLEANSBORO, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2010

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, 2010 includes three Level 2000 Errors.

2027 Worksheet C, Part I, Line 37, Col 11 should not be more than 100% or less than 1%.

The Hospital's operating room cost to charge ratio was 1.357781 as the number of surgeries in 2010 did not generate enough revenue to cover the expense of the Surgeons and related operating room supplies including allocated overhead.

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 1.137338 as the number of surgeries in 2010 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 2.925147 as the number of visits in 2010 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.

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: _09/24/2010
__ MANUALLY SUBMITTED COST REPORT — TIME: _08:25____

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 07/01/2009 AND ENDING 06/30/2010, 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: 09/24/2010 08:25
dTqZOjAhi5IyR3pBF8Mz0JvQeg1e00
UJSJM09yaYbq.fofQnP76YLWL9Bqaj
5qGb099IPP0NskWu

PI Encryption: 09/24/2010 08:25
EIpku0:4LaFA4aYiFYjU2NLxFaDFI0
CaXMI0oQOunzZv449kl6GUIeEcvAiS
C0ti8Wk5xI0aDLsQ

(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		195843	71415		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		147492			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			173224		9
100	TOTAL		343335	244639		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: 07/01/2009 TO: 06/30/2010 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? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO. 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 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO. NO 21.06

21.07 DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS). NO 21.07

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO. 21.08

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? NO 22

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW NO 23

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3. 23.01

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.02

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.03

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.04

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

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.06

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. 23.07

24 IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3. 24

24.01 IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3. 24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			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
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	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

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

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03.	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: 169576 PAID LOSSES: AND/OR SELF INSURANCE:		54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

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

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

MULTICAMPUS

61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO.		NO				61
	IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	COUNTY: 1	STATE: 2	ZIP CODE 3	CBSA 4	FTE/ CAMPUS 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)		YES	08/04/2010			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	59088.00		1937		208		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					774				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9125	59088.00		2711		208		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	59088.00		2711		208		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							1038		18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I							1177		24
25	TOTAL	85								25
26	OBSERVATION BED DAYS							112	27	26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28
29	LABOR & DELIVERY DAYS									29

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		2462								1
2	HMO X1X										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		774								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		71								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3307								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		3307						121.06		12
13	RPCH VISITS										13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY										15
16	NURSING FACILITY		16165						52.05		16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY		1274						3.34		18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I		3431						6.50		24
25	TOTAL								182.95		25
26	OBSERVATION BED DAYS	85	639	161	478						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28
29	LABOR & DELIVERY DAYS										29

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(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		612	95	848	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		612	95	848	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	6802923						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	1419080						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	758402	2632					22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	143130						24
25	LAUNDRY & LINEN SERVICE	80329						25
26	HOUSEKEEPING	166787						26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	17363	-2632					27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	276057						30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY	161666						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	159696						33
34	SOCIAL SERVICE	39655						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	6802923		6802923			1
2	EXCLUDED AREA SALARIES	1419080		1419080			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5383843		5383843			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	5383843		5383843			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	1803085		1803085			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		6			6	1
2	UNDUPLICATED CENSUS COUNT		63.00		17.00	80.00	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)	.70		.70	3
4	DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL	.74		.74	5
6	DIRECT NURSING SERVICE	1.37		1.37	6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE	.53		.53	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	309		15	62			386	21
22	SKILLED NURSING VISIT CHARGES	33990		1660	6820			42460	22
23	PHYSICAL THERAPY VISITS	329		4	52			385	23
24	PHYSICAL THERAPY VISIT CHARGES	36190		440	5720			42350	24
25	OCCUPATIONAL THERAPY VISITS	209			34			243	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	22990			3740			26730	26
27	SPEECH PATHOLOGY VISITS	7			11			18	27
28	SPEECH PATHOLOGY VISIT CHARGES	770			1210			1980	28
29	MEDICAL SOCIAL SERVICE VISITS								29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES								30
31	HOME HEALTH AIDE VISITS	6						6	31
32	HOME HEALTH AIDE VISIT CHARGES	540						540	32
33	TOTAL VISITS	860		19	159			1038	33
34	OTHER CHARGES								34
35	TOTAL CHARGES	94480		2090	17490			114060	35
36	TOTAL NUMBER OF EPISODES								36
37	TOTAL NUMBER OF OUTLIER EPISODES								37
38	TOTAL MEDICAL SUPPLY CHARGES	1345		408	396			2149	38

NHCMQ DEMONSTRATION STATISTICAL DATA WORKSHEET S-7
STATISTICAL DATA

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

RHC I
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			9
	PHYSICIAN NAME	HOURS	
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
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		701371	701371	733202	1434573	-35742	1398831	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		493076	493076	96403	589479	-4643	584836	4
5	0500	EMPLOYEE BENEFITS		1671130	1671130		1671130	-32343	1638787	5
6.01	0610	NONPATIENT TELEPHONES		28372	28372	-4256	24116		24116	6.01
6.02	0620	DATA PROCESSING	69442	10265	79707		79707		79707	6.02
6.03	0630	PURCHASING RECEIVING AND STORES	43810	3368	47178		47178	-401	46777	6.03
6.04	0640	ADMITTING				126960	126960		126960	6.04
6.05	0650	CASHIERING/ACCOUNTS RECEIVABLE	201968	210524	412492	-126960	285532		285532	6.05
6.06	0660	OTHER ADMINISTRATIVE AND GENERA	443182	262942	706124	139287	845411	-136102	709309	6.06
8	0800	OPERATION OF PLANT	143130	475777	618907	-6041	612866		612866	8
9	0900	LAUNDRY & LINEN SERVICE	80329	36858	117187		117187		117187	9
10	1000	HOUSEKEEPING	166787	30212	196999		196999		196999	10
11	1100	DIETARY	17363	73263	90626	-13739	76887	-81	76806	11
12	1200	CAFETERIA								12
14	1400	NURSING ADMINISTRATION	276057	9950	286007		286007		286007	14
15	1500	CENTRAL SERVICES & SUPPLY		16666	16666	8217	24883		24883	15
16	1600	PHARMACY	161666	349471	511137	-322521	188616		188616	16
17	1700	MEDICAL RECORDS & LIBRARY	159696	25602	185298		185298	-3973	181325	17
18	1800	SOCIAL SERVICE	39655	1178	40833		40833		40833	18
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	1135647	82829	1218476		1218476		1218476	25
35	3500	NURSING FACILITY	1259203	342758	1601961	85951	1687912	-8711	1679201	35
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	128582	158116	286698	-114908	171790		171790	37
40	4000	ANESTHESIOLOGY	233431	28444	261875	-5799	256076		256076	40
41	4100	RADIOLOGY-DIAGNOSTIC	309274	245008	554282	-9512	544770		544770	41
44	4400	LABORATORY	345220	483050	828270		828270		828270	44
49	4900	RESPIRATORY THERAPY	126529	27328	153857	-3407	150450		150450	49
50	5000	PHYSICAL THERAPY	288559	142102	430661	-3	430658	-7360	423298	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY		2725	2725		2725		2725	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				76374	76374	-17766	58608	55
56	5600	DRUGS CHARGED TO PATIENTS				279390	279390	-27405	251985	56
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	541984	628550	1170534	41601	1212135	-434784	777351	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC	471532	35777	507309	-52596	454713	-109982	344731	63.50
		OTHER REIMBURSABLE COST CENTERS								
71	7100	HOME HEALTH AGENCY	159877	62262	222139	4087	226226	-3922	222304	71
		SPECIAL PURPOSE COST CENTERS								
88	8800	INTEREST EXPENSE		777699	777699	-777699				88
90	9000	OTHER CAPITAL RELATED COSTS		28457	28457	-28457				90
94	6950	OTHER SPECIAL PURPOSE COST CENT								94
94.01	6951	INSURANCE AND MALPRACTICE		109219	109219	-109219				94.01
94.02	6952	SUPPLIES AND EXPENSE		16355	16355	-16355				94.02
95		SUBTOTALS	6802923	7570704	14373627		14373627	-823215	13550412	95
		NONREIMBURSABLE COST CENTERS								
98	9800	PHYSICIANS' PRIVATE OFFICES		97927	97927		97927		97927	98
101		TOTAL	6802923	7668631	14471554		14471554	-823215	13648339	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		777699	1
2	TO RECLASS CAFETERIA COSTS	B	OTHER ADMINISTRATIVE AND GENE	6.06	2632	11107	2
3	TO RECLASS RENT EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		139581	3
4		C					4
5		C					5
6	43	C					6
7		C					7
8		C					8
9		C					9
10	TO RECLASS INSURANCE EXPENSE	D	OTHER ADMINISTRATIVE AND GENE	6.06		132335	10
11		D					11
12		D					12
13	TO RECLASS SALARIES & OTHER EXP	E	ADMITTING	6.04	67255	59705	13
14	TO RECLASS SUPPLIES SOLD TO PATIENTS	F	MEDICAL SUPPLIES CHARGED TO P	55		76374	14
15		F					15
16		F					16
17		F					17
18		F					18
19		F					19
20		F					20
21	TO RECLASS DRUGS TO PHARMACY	G	DRUGS CHARGED TO PATIENTS	56		253672	21
22	TO RECLASS SUPPLIES SOLD	H	CENTRAL SERVICES & SUPPLY	15		16355	22
23	TO RECLASS NURSING CENTER PHONES	I	NURSING FACILITY	35		4256	23
24	TO RECLASS NURSING CENTER DEPRECIATI	J	NURSING FACILITY	35		105075	24
25		J					25
26	TO RECLASS IV COSTS	K	DRUGS CHARGED TO PATIENTS	56		25718	26
27	TO RECLASS AUDIT COST	L	OTHER ADMINISTRATIVE AND GENE	6.06		7234	27
28		L					28
29	TO RECLASS HHA DEPRECIATION	M	HOME HEALTH AGENCY	71		11057	29
30	TO RECLASS MALPRACTICE INSURANCE	N	OTHER ADMINISTRATIVE AND GENE	6.06		3705	30
31	TO RECLASS ER TIME FOR RHC PHYS	O	EMERGENCY	61	48891		31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				118778	1623873	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE LINE # 7	SALARY 8	OTHER 9	WKST A-7 REF. 10
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		777699	11 1
2	TO RECLASS CAFETERIA COSTS	B	DIETARY	11	2632	11107	2
3	TO RECLASS RENT EXPENSE	C	OTHER ADMINISTRATIVE AND GENE	6.06		17726	10 3
4		C	OPERATING ROOM	37		60997	4
5		C	RESPIRATORY THERAPY	49		1811	5
6	43	C	RADIOLOGY-DIAGNOSTIC	41		9500	6
7		C	PHARMACY	16		43131	7
8		C	OPERATION OF PLANT	8		6041	8
9		C	ANESTHESIOLOGY	40		375	9
10	TO RECLASS INSURANCE EXPENSE	D	INSURANCE AND MALPRACTICE	94.01		109219	10
11		D	NURSING FACILITY	35		19763	11
12		D	HOME HEALTH AGENCY	71		3353	12
13	TO RECLASS SALARIES & OTHER EXP	E	CASHIERING/ACCOUNTS RECEIVABL	6.05	67255	59705	13
14	TO RECLASS SUPPLIES SOLD TO PATIE	F	EMERGENCY	61		7290	14
15		F	ANESTHESIOLOGY	40		5424	15
16		F	OPERATING ROOM	37		53911	16
17		F	RESPIRATORY THERAPY	49		1596	17
18		F	PHYSICAL THERAPY	50		3	18
19		F	RADIOLOGY-DIAGNOSTIC	41		12	19
20		F	CENTRAL SERVICES & SUPPLY	15		8138	20
21	TO RECLASS DRUGS TO PHARMACY	G	PHARMACY	16		253672	21
22	TO RECLASS SUPPLIES SOLD	H	SUPPLIES AND EXPENSE	94.02		16355	22
23	TO RECLASS NURSING CENTER PHONES	I	NONPATIENT TELEPHONES	6.01		4256	23
24	TO RECLASS NURSING CENTER DEPRECI	J	NEW CAP REL COSTS-BLDG & FIXT	3		66999	9 24
25		J	NEW CAP REL COSTS-MVBLE EQUIP	4		38076	9 25
26	TO RECLASS IV COSTS	K	PHARMACY	16		25718	26
27	TO RECLASS AUDIT COST	L	NURSING FACILITY	35		3617	27
28		L	HOME HEALTH AGENCY	71		3617	28
29	TO RECLASS HHA DEPRECIATION	M	NEW CAP REL COSTS-MVBLE EQUIP	4		11057	9 29
30	TO RECLASS MALPRACTICE INSURANCE	N	RURAL HEALTH CLINIC	63.50		3705	30
31	TO RECLASS ER TIME FOR RHC PHYS	O	RURAL HEALTH CLINIC	63.50	48891		31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				118778	1623873	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				3191	71258		1
2	LAND IMPROVEMENTS	607333	6038		6038	6216	607155		2
3	BUILDINGS AND FIXTURES	11918756	8796405		8796405	602383	20112778		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	5316723	425745		425745	259562	5482906		6
7	SUBTOTAL	17917261	9228188		9228188	871352	26274097		7
8	RECONCILING ITEMS								8
9	TOTAL	17917261	9228188		9228188	871352	26274097		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS-BLDG & FIXT	20719930		20719930	.790751	22502			22502	3
4	NEW CAP REL COSTS-MVBLE EQUIP	5482906		5482906	.209249	5955			5955	4
5	TOTAL	26202836		26202836	1.000000	28457			28457	5

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	611870		741957	45004			1398831	3
4	NEW CAP REL COSTS-MVBLE EQUIP	433345	139581		11910			584836	4
5	TOTAL	1045215	139581	741957	56914			1983667	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	678869			22502			701371	3
4	NEW CAP REL COSTS-MVBLE EQUIP	487121			5955			493076	4
5	TOTAL	1165990			28457			1194447	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-35742	NEW CAP REL COSTS-BLDG & FIXT	3	11	3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS	B	-401	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	-6484	OTHER ADMINISTRATIVE AND GENERA	6.06		10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-251708				12
13	SALE OF SCRAP, WASTE, ETC.						13
14	RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1					14
15	LAUNDRY AND LINEN SERVICE						15
16	CAFETERIA - EMPLOYEES AND GUESTS	B	-81	DIETARY	11		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-17766	MEDICAL SUPPLIES CHARGED TO PAT	55		18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-27405	DRUGS CHARGED TO PATIENTS	56		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-3973	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES	B	-2358	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	-7409	OTHER ADMINISTRATIVE AND GENERA	6.06		37
38	HH COMMUNITY PROGRAM	B	-3545	HOME HEALTH AGENCY	71		38
39	PORTION OF LOBBYING DUES	A	-4156	OTHER ADMINISTRATIVE AND GENERA	6.06		39
40	WOMENS WELLNESS	B	-41038	OTHER ADMINISTRATIVE AND GENERA	6.06		40
41	PHYSICIAN RECRUITMENT	A	-12377	OTHER ADMINISTRATIVE AND GENERA	6.06		41
42	ADVERTISING	A	-37009	OTHER ADMINISTRATIVE AND GENERA	6.06		42
43	IDPA ASSESSMENTS	A	32850	OTHER ADMINISTRATIVE AND GENERA	6.06		43
44	BEAUTY SHOP	A	-4613	NURSING FACILITY	35		44
45	VNA THERAPHY SERVICES	A	-7360	PHYSICAL THERAPY	50		45
46	FUNDRAISING	A	-4643	NEW CAP REL COSTS-MVBLE EQUIP	4	9	46
47	NH DIETARY	B	-1035	NURSING FACILITY	35		47
48							48
49	NH SUPPLY TO OTHERS	A	-184	NURSING FACILITY	35		49
49.02	SURETY BOND	A	-100	NURSING FACILITY	35		49.02
49.03	FUND/MKT SALARIES	A	-36028	OTHER ADMINISTRATIVE AND GENERA	6.06		49.03
49.04	FUND/MKT BENEFITS	A	-9007	EMPLOYEE BENEFITS	5		49.04
49.06	FUNDRAISING	A	-22093	OTHER ADMINISTRATIVE AND GENERA	6.06		49.06
49.07	RHC ER SALARIES	A	-48891	EMERGENCY	61		49.07
49.08	ER PHYSICIAN BENEFITS	A	-7959	EMPLOYEE BENEFITS	5		49.08
49.09	NON RHC COST	A	-109982	RURAL HEALTH CLINIC	63.50		49.09
49.10	NON RHC BENEFITS	A	-13537	EMPLOYEE BENEFITS	5		49.10
49.13	VNA SEVICES BENEFITS	A	-1840	EMPLOYEE BENEFITS	5		49.13
49.14	ER PHYSICIAN COST	A	-134185	EMERGENCY	61		49.14
49.15	NH INTEREST INCOME	A	-2779	NURSING FACILITY	35		49.15
49.16	HHA ADVERTISING	A	-377	HOME HEALTH AGENCY	71		49.16
50	TOTAL		-823215				50

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

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
2 61	EMERGENCY	AGGREGATE	535548	251708	283840				
101	TOTAL		535548	251708	283840				

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							251708
101		TOTAL								251708

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	240	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		1693.25				9
10	AHSEA		66.46				10
11	STANDARD TRAVEL ALLOWANCE	33.23	33.23				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	112533	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	112533	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	112533	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	112533	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	7975	24
25	ASSISTANTS		25
26	SUBTOTAL	7975	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	7975	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	7975	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	112533	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	7975	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	120508	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	84664	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	65525	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	19139	66.31
67	TOTAL COST	84664	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.773942	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.226058	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	246	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		397.75				9
10	AHSEA		70.13				10
11	STANDARD TRAVEL ALLOWANCE	35.07	35.07				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	27894	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	27894	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	27894	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	70.13	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	54701	22
23	TOTAL SALARY EQUIVALENCY	54701	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	8627	24
25	ASSISTANTS		25
26	SUBTOTAL	8627	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	8627	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	8627	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

[ ] 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		57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	54701	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	8627	59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	63328	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	24630	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	22440	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	2190	66.31
67	TOTAL COST	24630	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.911084	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.088916	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	151	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		250.75				9
10	AHSEA		63.86				10
11	STANDARD TRAVEL ALLOWANCE	31.93	31.93				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	16013	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	16013	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	16013	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	63.86	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	49811	22
23	TOTAL SALARY EQUIVALENCY	49811	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	4821	24
25	ASSISTANTS		25
26	SUBTOTAL	4821	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4821	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	4821	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

[ ] 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	49811	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	4821	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	54632	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	14287	64
65	EXCESS OVER LIMITATION		65

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	12451	66
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I	1836	66.31
67	TOTAL COST	14287	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	.871492	68
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I	.128508	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 STOR 6.03	ADMITTING 6.04	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	1398831	1398831							3
4	NEW CAP REL COSTS-MVBLE EQUIP	584836		584836						4
5	EMPLOYEE BENEFITS	1638787			1638787					5
6.01	NONPATIENT TELEPHONES	24116	771	322		25209				6.01
6.02	DATA PROCESSING	79707	2467	1031	17599		100804			6.02
6.03	PURCHASING RECEIVING AND STORES	46777	31468	13156	11103	360		102864		6.03
6.04	ADMITTING	126960			17044				144004	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	285532	30639	12810	34140	540	81777			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	709309	193738	81000	103851	4143	19027	1010		6.06
8	OPERATION OF PLANT	612866	137201	57362	36273	540		4516		8
9	LAUNDRY & LINEN SERVICE	117187	18422	7702	20358	180		475		9
10	HOUSEKEEPING	196999			42268			2065		10
11	DIETARY	76806	12275	5132	3733			143		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION	286007	18364	7678	69961	900		165		14
15	CENTRAL SERVICES & SUPPLY	24883	5280	2207				1397		15
16	PHARMACY	188616	6610	2763	40971			24198		16
17	MEDICAL RECORDS & LIBRARY	181325	42817	17901	40471	1080		971		17
18	SOCIAL SERVICE	40833	3700	1547	10050	900		120		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1218476	222893	93189	287805	3781		6556	35610	25
35	NURSING FACILITY	1679201			319117	3061		5602		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	171790	129107	53978	32586	1441		7497	3102	37
40	ANESTHESIOLOGY	256076	2948	1233	59158			1469	1545	40
41	RADIOLOGY-DIAGNOSTIC	544770	55535	23219	78379	1981		2490	17581	41
44	LABORATORY	828270	29367	12278	87488	540		33106	22197	44
49	RESPIRATORY THERAPY	150450	13816	5776	32066	720		1606	20109	49
50	PHYSICAL THERAPY	423298	25590	10699	71264	180		598	4497	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	2725							1869	53
55	MEDICAL SUPPLIES CHARGED TO PAT	58608							1019	55
56	DRUGS CHARGED TO PATIENTS	251985							34008	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	777351	95443	39904	103348	1441		6870	54	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	344731	240179	100418	79237	2341		1646	2413	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY	222304			40517	360		364		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	13550412	1318630	551305	1638787	24489	100804	102864	144004	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	97927	80201	33531		720				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	13648339	1398831	584836	1638787	25209	100804	102864	144004	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	445438								6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		1112078	1112078						6.06
8	OPERATION OF PLANT		848758	75292	924050					8
9	LAUNDRY & LINEN SERVICE		164324	14577	16979	195880				9
10	HOUSEKEEPING		241332	21408		6697	269437			10
11	DIETARY		98089	8701	11314	1337	7647	127088		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		383075	33982	16926		1140		435123	14
15	CENTRAL SERVICES & SUPPLY		33767	2995	4867					15
16	PHARMACY		263158	23344	6092					16
17	MEDICAL RECORDS & LIBRARY		284565	25243	39465					17
18	SOCIAL SERVICE		57150	5070	3410					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	43985	1912295	169638	205441	19978	125646	127088	356464	25
35	NURSING FACILITY		2006981	178039		158282				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	14941	414442	36765	118998	1250	34196		24510	37
40	ANESTHESIOLOGY	7130	329559	29235	2717					40
41	RADIOLOGY-DIAGNOSTIC	86816	810471	71896	51187	1287	9618			41
44	LABORATORY	110872	1124118	99719	27068		8549			44
49	RESPIRATORY THERAPY	22287	246830	21896	12735					49
50	PHYSICAL THERAPY	24687	560813	49749	23587	3050	11399			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	8262	12856	1140						53
55	MEDICAL SUPPLIES CHARGED TO PAT	4507	64134	5689						55
56	DRUGS CHARGED TO PATIENTS	53512	339505	30117						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	60333	1084744	96227	87970	3999	37046		54149	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	8406	779371	69137	221373		34196			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY		263545	23379						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	445438	13435960	1093238	850129	195880	269437	127088	435123	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		212379	18840	73921					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	445438	13648339	1112078	924050	195880	269437	127088	435123	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	41629							15
16	PHARMACY		292594						16
17	MEDICAL RECORDS & LIBRARY			349273					17
18	SOCIAL SERVICE				65630				18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS			160035	16194	3092779		3092779	25
35	NURSING FACILITY					2343302		2343302	35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM					630161		630161	37
40	ANESTHESIOLOGY					361511		361511	40
41	RADIOLOGY-DIAGNOSTIC			78477		1022936		1022936	41
44	LABORATORY			49111		1308565		1308565	44
49	RESPIRATORY THERAPY					281461		281461	49
50	PHYSICAL THERAPY				7955	656553		656553	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY					13996		13996	53
55	MEDICAL SUPPLIES CHARGED TO PAT	41629				111452		111452	55
56	DRUGS CHARGED TO PATIENTS		287960			657582		657582	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY			61650	21877	1447662		1447662	61
62	OBSERVATION BEDS (NON-DISTINCT								62
63.50	RURAL HEALTH CLINIC		4634		14206	1122917		1122917	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY				5398	292322		292322	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	41629	292594	349273	65630	13343199		13343199	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES					305140		305140	98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	TOTAL	41629	292594	349273	65630	13648339		13648339	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	CASHIERING/ACCOUNTS RECEIVABLE 6.05	
	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		771	322	1093	1093				6.01
6.02	DATA PROCESSING		2467	1031	3498		3498			6.02
6.03	PURCHASING RECEIVING AND STORES		31468	13156	44624	16		44640		6.03
6.04	ADMITTING									6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE		30639	12810	43449	23	2838		46310	6.05
6.06	OTHER ADMINISTRATIVE AND GENERA		193738	81000	274738	181	660	438		6.06
8	OPERATION OF PLANT		137201	57362	194563	23		1960		8
9	LAUNDRY & LINEN SERVICE		18422	7702	26124	8		206		9
10	HOUSEKEEPING							896		10
11	DIETARY		12275	5132	17407			62		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION		18364	7678	26042	39		72		14
15	CENTRAL SERVICES & SUPPLY		5280	2207	7487			606		15
16	PHARMACY		6610	2763	9373			10501		16
17	MEDICAL RECORDS & LIBRARY		42817	17901	60718	47		421		17
18	SOCIAL SERVICE		3700	1547	5247	39		52		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		222893	93189	316082	164		2845	4572	25
35	NURSING FACILITY					133		2431		35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		129107	53978	183085	62		3253	1553	37
40	ANESTHESIOLOGY		2948	1233	4181			637	741	40
41	RADIOLOGY-DIAGNOSTIC		55535	23219	78754	86		1081	8993	41
44	LABORATORY		29367	12278	41645	23		14369	11534	44
49	RESPIRATORY THERAPY		13816	5776	19592	31		697	2317	49
50	PHYSICAL THERAPY		25590	10699	36289	8		259	2566	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY								859	53
55	MEDICAL SUPPLIES CHARGED TO PAT								468	55
56	DRUGS CHARGED TO PATIENTS								5562	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		95443	39904	135347	62		2982	6271	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC		240179	100418	340597	101		714	874	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY					16		158		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		1318630	551305	1869935	1062	3498	44640	46310	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES		80201	33531	113732	31				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		1398831	584836	1983667	1093	3498	44640	46310	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE 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	PHARMACY 16	
	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	276017								6.06
8	OPERATION OF PLANT	18687	215233							8
9	LAUNDRY & LINEN SERVICE	3618	3955	33911						9
10	HOUSEKEEPING	5313		1159	7368					10
11	DIETARY	2160	2635	231	209	22704				11
12	CAFETERIA									12
14	NURSING ADMINISTRATION	8434	3943		31		38561			14
15	CENTRAL SERVICES & SUPPLY	743	1134					9970		15
16	PHARMACY	5794	1419						27087	16
17	MEDICAL RECORDS & LIBRARY	6265	9192							17
18	SOCIAL SERVICE	1258	794							18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	42103	47852	3459	3436	22704	31590			25
35	NURSING FACILITY	44196		27403						35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	9125	27718	216	935		2172			37
40	ANESTHESIOLOGY	7256	633							40
41	RADIOLOGY-DIAGNOSTIC	17844	11923	223	263					41
44	LABORATORY	24750	6305		234					44
49	RESPIRATORY THERAPY	5434	2966							49
50	PHYSICAL THERAPY	12347	5494	528	312					50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	283								53
55	MEDICAL SUPPLIES CHARGED TO PAT	1412						9970		55
56	DRUGS CHARGED TO PATIENTS	7475							26658	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	23883	20490	692	1013		4799			61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	17159	51562		935				429	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY	5802								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	271341	198015	33911	7368	22704	38561	9970	27087	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES	4676	17218							98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	276017	215233	33911	7368	22704	38561	9970	27087	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	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						16
17	MEDICAL RECORDS & LIBRARY	76643					17
18	SOCIAL SERVICE		7390				18
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	35117	1824	511748		511748	25
35	NURSING FACILITY			74163		74163	35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM			228119		228119	37
40	ANESTHESIOLOGY			13448		13448	40
41	RADIOLOGY-DIAGNOSTIC	17221		136388		136388	41
44	LABORATORY	10777		109637		109637	44
49	RESPIRATORY THERAPY			31037		31037	49
50	PHYSICAL THERAPY		896	58699		58699	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY			1142		1142	53
55	MEDICAL SUPPLIES CHARGED TO PAT			11850		11850	55
56	DRUGS CHARGED TO PATIENTS			39695		39695	56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	13528	2462	211529		211529	61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RURAL HEALTH CLINIC		1600	413971		413971	63.50
	OTHER REIMBURSABLE COST CENTERS						
71	HOME HEALTH AGENCY		608	6584		6584	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	76643	7390	1848010		1848010	95
	NONREIMBURSABLE COST CENTERS						
98	PHYSICIANS' PRIVATE OFFICES			135657		135657	98
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL	76643	7390	1983667		1983667	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	72592							3
4	NEW CAP REL COSTS-MVBLE EQUIP		72592						4
5	EMPLOYEE BENEFITS			6466476					5
6.01	NONPATIENT TELEPHONES	40	40		140				6.01
6.02	DATA PROCESSING	128	128	69442		249			6.02
6.03	PURCHASING RECEIVING AND STOR	1633	1633	43810	2		1226935		6.03
6.04	ADMITTING			67255				6066363	6.04
6.05	CASHIERING/ACCOUNTS RECEIVABL	1590	1590	134713	3	202			6.05
6.06	OTHER ADMINISTRATIVE AND GENE	10054	10054	409786	23	47	12051		6.06
8	OPERATION OF PLANT	7120	7120	143130	3		53866		8
9	LAUNDRY & LINEN SERVICE	956	956	80329	1		5669		9
10	HOUSEKEEPING			166787			24632		10
11	DIETARY	637	637	14730			1703		11
12	CAFETERIA								12
14	NURSING ADMINISTRATION	953	953	276057	5		1968		14
15	CENTRAL SERVICES & SUPPLY	274	274				16667		15
16	PHARMACY	343	343	161666			288626		16
17	MEDICAL RECORDS & LIBRARY	2222	2222	159696	6		11584		17
18	SOCIAL SERVICE	192	192	39655	5		1430		18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	11567	11567	1135647	21		78202	1500056	25
35	NURSING FACILITY			1259203	17		66821		35
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	6700	6700	128582	8		89418	130664	37
40	ANESTHESIOLOGY	153	153	233431			17518	65092	40
41	RADIOLOGY-DIAGNOSTIC	2882	2882	309274	11		29703	740647	41
44	LABORATORY	1524	1524	345220	3		394859	935088	44
49	RESPIRATORY THERAPY	717	717	126529	4		19157	847119	49
50	PHYSICAL THERAPY	1328	1328	281199	1		7131	189438	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY							78751	53
55	MEDICAL SUPPLIES CHARGED TO P							42943	55
56	DRUGS CHARGED TO PATIENTS							1432649	56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	4953	4953	407799	8		81949	2261	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC	12464	12464	312659	13		19636	101655	63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY			159877	2		4345		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	68430	68430	6466476	136	249	1226935	6066363	95
	NONREIMBURSABLE COST CENTERS								
98	PHYSICIANS' PRIVATE OFFICES	4162	4162		4				98
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	1398831	584836	1638787	25209	100804	102864	144004	103
104	UNIT COST MULT-WS B PT I		8.056480		180.064286		.083838		104
104	UNIT COST MULT-WS B PT I	19.269768		.253428		404.835341		.023738	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				1093	3498	44640		107
108	UNIT COST MULT-WS B PT III				7.807143		.036383		108
108	UNIT COST MULT-WS B PT III					14.048193			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	20343110								6.05
6.06	OTHER ADMINISTRATIVE AND GENE		-1112078	12536261						6.06
8	OPERATION OF PLANT			848758	52027					8
9	LAUNDRY & LINEN SERVICE			164324	956	692180				9
10	HOUSEKEEPING			241332		23665	11346			10
11	DIETARY			98089	637	4724	322	11052		11
12	CAFETERIA									12
14	NURSING ADMINISTRATION			383075	953		48		94587	14
15	CENTRAL SERVICES & SUPPLY			33767	274					15
16	PHARMACY			263158	343					16
17	MEDICAL RECORDS & LIBRARY			284565	2222					17
18	SOCIAL SERVICE			57150	192					18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	2008793		1912295	11567	70596	5291	11052	77488	25
35	NURSING FACILITY			2006981		559322				35
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	682368		414442	6700	4418	1440		5328	37
40	ANESTHESIOLOGY	325608		329559	153					40
41	RADIOLOGY-DIAGNOSTIC	3951220		810471	2882	4547	405			41
44	LABORATORY	5063391		1124118	1524		360			44
49	RESPIRATORY THERAPY	1017873		246830	717					49
50	PHYSICAL THERAPY	1127446		560813	1328	10777	480			50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	377328		12856						53
55	MEDICAL SUPPLIES CHARGED TO P	205828		64134						55
56	DRUGS CHARGED TO PATIENTS	2443939		339505						56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	2755432		1084744	4953	14131	1560		11771	61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RURAL HEALTH CLINIC	383884		779371	12464		1440			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY			263545						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	20343110	-1112078	12323882	47865	692180	11346	11052	94587	95
	NONREIMBURSABLE COST CENTERS									
98	PHYSICIANS' PRIVATE OFFICES			212379	4162					98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	445438		1112078	924050	195880	269437	127088	435123	103
104	UNIT COST MULT-WS B PT I	.021896		.088709		.282990		11.499095		104
104	UNIT COST MULT-WS B PT I				17.760970		23.747312		4.600241	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	46310		276017	215233	33911	7368	22704	38561	107
108	UNIT COST MULT-WS B PT III	.002276		.022017		.048992		2.054289		108
108	UNIT COST MULT-WS B PT III				4.136948		.649392		.407678	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	76374				15
16	PHARMACY		296819			16
17	MEDICAL RECORDS & LIBRARY			69163		17
18	SOCIAL SERVICE				6930	18
	INPATIENT ROUTINE SERV COST CENTERS					
25	ADULTS & PEDIATRICS			31690	1710	25
35	NURSING FACILITY					35
	ANCILLARY SERVICE COST CENTERS					
37	OPERATING ROOM					37
40	ANESTHESIOLOGY					40
41	RADIOLOGY-DIAGNOSTIC			15540		41
44	LABORATORY			9725		44
49	RESPIRATORY THERAPY					49
50	PHYSICAL THERAPY				840	50
51	OCCUPATIONAL THERAPY					51
52	SPEECH PATHOLOGY					52
53	ELECTROCARDIOLOGY					53
55	MEDICAL SUPPLIES CHARGED TO P	76374				55
56	DRUGS CHARGED TO PATIENTS		292118			56
	OUTPATIENT SERVICE COST CENTERS					
61	EMERGENCY			12208	2310	61
62	OBSERVATION BEDS (NON-DISTINC					62
63.50	RURAL HEALTH CLINIC		4701		1500	63.50
	OTHER REIMBURSABLE COST CENTERS					
71	HOME HEALTH AGENCY				570	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	76374	296819	69163	6930	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	41629	292594	349273	65630	103
104	UNIT COST MULT-WS B PT I	.545068		5.049998		104
104	UNIT COST MULT-WS B PT I		.985766		9.470418	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	9970	27087	76643	7390	107
108	UNIT COST MULT-WS B PT III	.130542		1.108150		108
108	UNIT COST MULT-WS B PT III		.091258		1.066378	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	3092779		3092779		3092779	25
35	NURSING FACILITY	2343302		2343302		2343302	35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	630161		630161		630161	37
40	ANESTHESIOLOGY	361511		361511		361511	40
41	RADIOLOGY-DIAGNOSTIC	1022936		1022936		1022936	41
44	LABORATORY	1308565		1308565		1308565	44
49	RESPIRATORY THERAPY	281461		281461		281461	49
50	PHYSICAL THERAPY	656553		656553		656553	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	13996		13996		13996	53
55	MEDICAL SUPPLIES CHARGED TO	111452		111452		111452	55
56	DRUGS CHARGED TO PATIENTS	657582		657582		657582	56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	1447662		1447662		1447662	61
62	OBSERVATION BEDS (NON-DISTI	508618		508618		508618	62
63.50	RURAL HEALTH CLINIC	1122917		1122917		1122917	63.50
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	13559495		13559495		13559495	101
102	LESS OBSERVATION BEDS	508618		508618		508618	102
103	TOTAL	13050877		13050877		13050877	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	1539951		1539951				25
35	NURSING FACILITY	1541131		1541131				35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	49475	414636	464111	1.357781	1.357781	1.357781	37
40	ANESTHESIOLOGY	63006	254851	317857	1.137338	1.137338	1.137338	40
41	RADIOLOGY-DIAGNOSTIC	720222	3134323	3854545	.265384	.265384	.265384	41
44	LABORATORY	935088	4128303	5063391	.258436	.258436	.258436	44
49	RESPIRATORY THERAPY	382744	108933	491677	.572451	.572451	.572451	49
50	PHYSICAL THERAPY	195611	931376	1126987	.582574	.582574	.582574	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	78751	298577	377328	.037092	.037092	.037092	53
55	MEDICAL SUPPLIES CHARGED TO	611045	448450	1059495	.105194	.105194	.105194	55
56	DRUGS CHARGED TO PATIENTS	1432649	1011290	2443939	.269066	.269066	.269066	56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	2261	1677310	1679571	.861924	.861924	.861924	61
62	OBSERVATION BEDS (NON-DISTI	1255	467587	468842	1.084839	1.084839	1.084839	62
63.50	RURAL HEALTH CLINIC	101655	282229	383884	2.925147	2.925147	2.925147	63.50
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	7654844	13157865	20812709				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	7654844	13157865	20812709				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	1.357781	1.357781	1.357781				37
40	ANESTHESIOLOGY	1.137338	1.137338	1.137338				40
41	RADIOLOGY-DIAGNOSTIC	.265384	.265384	.265384				41
44	LABORATORY	.258436	.258436	.258436				44
49	RESPIRATORY THERAPY	.572451	.572451	.572451				49
50	PHYSICAL THERAPY	.582574	.582574	.582574				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.037092	.037092	.037092				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.105194	.105194	.105194				55
56	DRUGS CHARGED TO PATIENTS	.269066	.269066	.269066				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.861924	.861924	.861924				61
62	OBSERVATION BEDS (NON-DISTINCT	1.084839	1.084839	1.084839				62
63.50	RURAL HEALTH CLINIC	2.925147	2.925147	2.925147				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	.269066	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES						
	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1326)	[ ]	SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES: ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES: ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES: PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST: OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST: OUTPATIENT RADIOLOGY 7	PROGRAM COST: OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	245538								37
40	ANESTHESIOLOGY	86407								40
41	RADIOLOGY-DIAGNOSTIC	1040588								41
44	LABORATORY	1994205								44
49	RESPIRATORY THERAPY	57406								49
50	PHYSICAL THERAPY	383601								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	174730								53
55	MEDICAL SUPPLIES CHARGED TO PA	176841								55
56	DRUGS CHARGED TO PATIENTS	419983								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	636470								61
62	OBSERVATION BEDS (NON-DISTINCT	220417								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	5436186								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	5436186								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	333387							37
40	ANESTHESIOLOGY	98274							40
41	RADIOLOGY-DIAGNOSTIC	276155							41
44	LABORATORY	515374							44
49	RESPIRATORY THERAPY	32862							49
50	PHYSICAL THERAPY	223476							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	6481							53
55	MEDICAL SUPPLIES CHARGED TO PAT	18603							55
56	DRUGS CHARGED TO PATIENTS	113003							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	548589							61
62	OBSERVATION BEDS (NON-DISTINCT	239117							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	2405321							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	2405321							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				511748	103337	408411	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				511748		408411	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	3101	208			131.70	27394	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	3101	208				27394	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	228119	464111	17708				.491518	8704	37
40	ANESTHESIOLOGY	13448	317857	21849				.042308	924	40
41	RADIOLOGY-DIAGNOSTIC	136388	3854545	76826				.035384	2718	41
44	LABORATORY	109637	5063391	72633				.021653	1573	44
49	RESPIRATORY THERAPY	31037	491677	17487				.063125	1104	49
50	PHYSICAL THERAPY	58699	1126987	3392				.052085	177	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	1142	377328	20871				.003027	63	53
55	MEDICAL SUPPLIES CHARGED TO P	11850	1059495	100679				.011185	1126	55
56	DRUGS CHARGED TO PATIENTS	39695	2443939	94868				.016242	1541	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	211529	1679571	600				.125942	76	61
62	OBSERVATION BEDS (NON-DISTINC		468842							62
63.50	RURAL HEALTH CLINIC		383884							63.50
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL	841544	17347743	426913					18006	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					3101		208		25
26	INTENSIVE CARE UNIT									26
27	CORONARY CARE UNIT									27
28	BURN INTENSIVE CARE UNIT									28
29	SURGICAL INTENSIVE CARE UNIT									29
30	OTHER SPECIAL CARE (SPECIFY)									30
31	SUBPROVIDER I									31
33	NURSERY									33
34	SKILLED NURSING FACILITY									34
35	NURSING FACILITY									35
101	TOTAL					3101		208		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

CHECK APPLICABLE BOXES								
	[ ]	TITLE V	[XX]	HOSPITAL (14-1326)	[ ]	SUB 1V	[ ]	PPS
	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	OUTPATIENT NONPHYSICIAN ANESTHETIST COST 1.01	MEDICAL EDUCATION COST 2	N/A 2.01	N/A 2.02	N/A 2.03	TOTAL COSTS 3	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM								37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC								41
44	LABORATORY								44
49	RESPIRATORY THERAPY								49
50	PHYSICAL THERAPY								50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY								53
55	MEDICAL SUPPLIES CHARGED TO P								55
56	DRUGS CHARGED TO PATIENTS								56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY								61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC								63.50
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL								101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

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

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		464111			17708			37
40	ANESTHESIOLOGY		317857			21849			40
41	RADIOLOGY-DIAGNOSTIC		3854545			76826			41
44	LABORATORY		5063391			72633			44
49	RESPIRATORY THERAPY		491677			17487			49
50	PHYSICAL THERAPY		1126987			3392			50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY		377328			20871			53
55	MEDICAL SUPPLIES CHARGED TO P		1059495			100679			55
56	DRUGS CHARGED TO PATIENTS		2443939			94868			56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		1679571			600			61
62	OBSERVATION BEDS (NON-DISTINC		468842						62
63.50	RURAL HEALTH CLINIC		383884						63.50
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		17347743			426913			101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART IV

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

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY						53
55	MEDICAL SUPPLIES CHARGED TO P						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RURAL HEALTH CLINIC						63.50
	OTHER REIMBURSABLE COST CENTERS						
101	TOTAL						101

APPORTIONMENT OF 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	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	1.357781	1.357781	1.357781				37
40	ANESTHESIOLOGY	1.137338	1.137338	1.137338				40
41	RADIOLOGY-DIAGNOSTIC	.265384	.265384	.265384				41
44	LABORATORY	.258436	.258436	.258436				44
49	RESPIRATORY THERAPY	.572451	.572451	.572451				49
50	PHYSICAL THERAPY	.582574	.582574	.582574				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.037092	.037092	.037092				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.105194	.105194	.105194				55
56	DRUGS CHARGED TO PATIENTS	.269066	.269066	.269066				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.861924	.861924	.861924				61
62	OBSERVATION BEDS (NON-DISTINCT	1.084839	1.084839	1.084839				62
63.50	RURAL HEALTH CLINIC	2.925147	2.925147	2.925147				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	.269066	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	24341								37
40	ANESTHESIOLOGY	30364								40
41	RADIOLOGY-DIAGNOSTIC	735958								41
44	LABORATORY	858972								44
49	RESPIRATORY THERAPY	16833								49
50	PHYSICAL THERAPY	142395								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	60584								53
55	MEDICAL SUPPLIES CHARGED TO PA	74157								55
56	DRUGS CHARGED TO PATIENTS	370494								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	466548								61
62	OBSERVATION BEDS (NON-DISTINCT	123994								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	2904640								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	2904640								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	33050							37
40	ANESTHESIOLOGY	34534							40
41	RADIOLOGY-DIAGNOSTIC	195311							41
44	LABORATORY	221989							44
49	RESPIRATORY THERAPY	9636							49
50	PHYSICAL THERAPY	82956							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	2247							53
55	MEDICAL SUPPLIES CHARGED TO PAT	7801							55
56	DRUGS CHARGED TO PATIENTS	99687							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	402129							61
62	OBSERVATION BEDS (NON-DISTINCT	134514							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	1223854							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1223854							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)	3946						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3101						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3101						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	387						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	387						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	36						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	35						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1937						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	387						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	387						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	117.51						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.51						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3092779						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	4230						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	4218						25
26 TOTAL SWING-BED COST	624521						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2468258						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1257666						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1257666						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.962570						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	405.57						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	2468258						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	795.96					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1541775					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1541775					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	758606					48
49	TOTAL PROGRAM INPATIENT COSTS	2300381					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	308037	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	308037	61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	616074	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	639					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	795.96					84
85 OBSERVATION BED COST	508618					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)	3946						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3101						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3101						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	387						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	387						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	36						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	35						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	208						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	117.51						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.51						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3092779						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	4230						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	4218						25
26	TOTAL SWING-BED COST	624521						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2468258						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1257666						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1257666						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.962570						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	405.57						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	2468258						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	795.96					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	165560					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	165560					41

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

		HOSPITAL (PPS) (14-1326)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	137447					48
49	TOTAL PROGRAM INPATIENT COSTS	303007					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	27394					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	18006					51
52	TOTAL PROGRAM EXCLUDABLE COST	45400					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	257607					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	639					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	795.96					84
85 OBSERVATION BED COST	508618					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	2468258		508618		86
87	NEW CAPITAL-RELATED COST	2468258		508618		87
88	NON PHYSICIAN ANESTHETIST	2468258		508618		88
89	MEDICAL EDUCATION	2468258		508618		89

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

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

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

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

[ ] PPS
[ ] TEFRA
[XX] 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		1041190		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	1.357781	22351	30348	37
40	ANESTHESIOLOGY	1.137338	25532	29039	40
41	RADIOLOGY-DIAGNOSTIC	.265384	463422	122985	41
44	LABORATORY	.258436	629595	162710	44
49	RESPIRATORY THERAPY	.572451	152585	87347	49
50	PHYSICAL THERAPY	.582574	87802	51151	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.037092	47126	1748	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.105194	343215	36104	55
56	DRUGS CHARGED TO PATIENTS	.269066	878783	236451	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.861924	839	723	61
62	OBSERVATION BEDS (NON-DISTINCT	1.084839			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	2.925147			63.50
101	TOTAL		2651250	758606	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		2651250		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	1.357781	5180	7033	37
40	ANESTHESIOLOGY	1.137338	4713	5360	40
41	RADIOLOGY-DIAGNOSTIC	.265384	68113	18076	41
44	LABORATORY	.258436	121626	31433	44
49	RESPIRATORY THERAPY	.572451	67556	38672	49
50	PHYSICAL THERAPY	.582574	87387	50909	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.037092	4445	165	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.105194	130074	13683	55
56	DRUGS CHARGED TO PATIENTS	.269066	350958	94431	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.861924	476	410	61
62	OBSERVATION BEDS (NON-DISTINCT	1.084839			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	2.925147			63.50
101	TOTAL		840528	260172	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		840528		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		102510		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	1.357781	17708	24044	37
40	ANESTHESIOLOGY	1.137338	21849	24850	40
41	RADIOLOGY-DIAGNOSTIC	.265384	76826	20388	41
44	LABORATORY	.258436	72633	18771	44
49	RESPIRATORY THERAPY	.572451	17487	10010	49
50	PHYSICAL THERAPY	.582574	3392	1976	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.037092	20871	774	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.105194	100679	10591	55
56	DRUGS CHARGED TO PATIENTS	.269066	94868	25526	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.861924	600	517	61
62	OBSERVATION BEDS (NON-DISTINCT	1.084839			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	2.925147			63.50
101	TOTAL		426913	137447	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		426913		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1326) 1	HOSPITAL (14-1326) 1.01	HOSPITAL (14-1326) 1.02	
1	MEDICAL AND OTHER SERVICES	2405321			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	2405321			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	2429374			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	26453			18
18.01	COINSURANCE	687193			18.01
19	SUBTOTAL	1715728			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	1715728			23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL	1715728			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	158747			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	158747			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28	SUBTOTAL	1874475			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	1874475			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1803060			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	71415			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT				51
52	THE RATE USED TO CALCULATE THE TIME VALUE				52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54	TOTAL (SUM OF LINES 51 AND 53)				54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
HOSPITAL (14-1326)

WORKSHEET E-1

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				1694983		1698276	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	01/08/2010	11836	01/08/2010	82622	3.01
	PROGRAM	.02	11/13/2009	67074	11/13/2009	22162	3.02
	TO	.03					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		78910		104784	3.99
4 TOTAL INTERIM PAYMENTS				1773893		1803060	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		195843		71415	6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				1969736		1874475	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				698961			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	01/08/2010	9146			3.01
	PROGRAM	.02	11/13/2009	14704			3.02
	TO	.03				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		23850			3.99
4 TOTAL INTERIM PAYMENTS				722811			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		147492			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				870303			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		622235				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		262774				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		774				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		885009				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		885009				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		885009				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		14706				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		870303				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		870303				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		722811				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		147492				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	2300381						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	2300381						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2323385						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	2323385						19
20	DEDUCTIBLES	426358						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	1897027						22
23	COINSURANCE							23
24	SUBTOTAL	1897027						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	72709						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	72709						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	1969736						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	1969736						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	1773893						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	195843						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	1223854						2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	1223854						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	1223854						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES	3331553						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	1223854						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	1223854						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	1335483				1
2	TEMPORARY INVESTMENTS	502780				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3053806				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-798000				6
7	INVENTORY	395805				7
8	PREPAID EXPENSES	272889				8
9	OTHER CURRENT ASSETS	648036				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	5410799				11
	FIXED ASSETS					
12	LAND	69760				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	591372				13
13.01	ACCUMULATED DEPRECIATION	-220230				13.01
14	BUILDINGS	20443594				14
14.01	ACCUMULATED DEPRECIATION	-3621567				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	5083963				18
18.01	ACCUMULATED DEPRECIATION	-3675433				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	18671459				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	2315605		101044		25
26	TOTAL OTHER ASSETS	2315605		101044		26
27	TOTAL ASSETS	26397863		101044		27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	455711				28
29	SALARIES, WAGES & FEES PAYABLE	497588				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	433056				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	330177				35
36	TOTAL CURRENT LIABILITIES	1716532				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE					38
39	UNSECURED LOANS	17935000				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES	3175000				41
42	TOTAL LONG TERM LIABILITIES	21110000				42
43	TOTAL LIABILITIES	22826532				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	3571331				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED			101044		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	3571331		101044		51
52	TOTAL LIABILITIES AND FUND BALANCES	26397863		101044		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	6284854		103823		1
2	NET INCOME (LOSS)	-2713523				2
3	TOTAL	3571331		103823		3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	3571331		103823		11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)			2779		12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS			2779		18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	3571331		101044		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	1257666		1257666	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	135095		135095	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	1392761		1392761	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	1392761		1392761	16
17	ANCILLARY SERVICES	4578075	12922986	17501061	17
18	OUTPATIENT SERVICES		1071532	1071532	18
18.50	RURAL HEALTH CLINIC	101655	282229	383884	18.50
19	HOME HEALTH AGENCY		142069	142069	19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24	OTHER	1541131		1541131	24
25	TOTAL PATIENT REVENUES	7613622	14418816	22032438	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		14471554	26
27	BAD DEBTS	1258597		27
28	LOSS ON SWAP CONTRACT			28
29	IMPAIRMENT LOSS ON NURSING HOME			29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1258597	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		15730151	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	22032438	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	8159393	2
3	NET PATIENT REVENUES	13873045	3
4	LESS - TOTAL OPERATING EXPENSES	15730151	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1857106	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	171424	6
7	INCOME FROM INVESTMENTS	38834	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	401	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	17766	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	27405	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	428957	23
24	OTHER	127894	24
25	TOTAL OTHER INCOME	812681	25
26	TOTAL	-1044425	26
27	LOSS ON SWAP CONTRACT	871000	27
27.01	IMPAIRMENT LOSS ON NURSING HOME	798098	27.01
28			28
29			29
30	TOTAL OTHER EXPENSES	1669098	30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-2713523	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	59032				22915	81947	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	65607				9857	75464	6
7	PHYSICAL THERAPY	35079			2190	4011	41280	7
8	OCCUPATIONAL THERAPY				19139		19139	8
9	SPEECH PATHOLOGY				1836		1836	9
10	MEDICAL SOCIAL SERVICES					150	150	10
11	HOME HEALTH AIDE	159					159	11
12	SUPPLIES					2329	2329	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	159877			23165	39262	222304	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		81947		81947	5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		75464		75464	6
7	PHYSICAL THERAPY		41280		41280	7
8	OCCUPATIONAL THERAPY		19139		19139	8
9	SPEECH PATHOLOGY		1836		1836	9
10	MEDICAL SOCIAL SERVICES		150		150	10
11	HOME HEALTH AIDE		159		159	11
12	SUPPLIES		2329		2329	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		222304		222304	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	81947					81947	81947		5
	HHA REIMBURSABLE SERVICES									
6	SKILLED NURSING CARE	75464					75464	44059	119523	6
7	PHYSICAL THERAPY	41280					41280	24101	65381	7
8	OCCUPATIONAL THERAPY	19139					19139	11174	30313	8
9	SPEECH PATHOLOGY	1836					1836	1072	2908	9
10	MEDICAL SOCIAL SERVICES	150					150	88	238	10
11	HOME HEALTH AIDE	159					159	93	252	11
12	SUPPLIES	2329					2329	1360	3689	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	222304					222304		222304	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7167

WORKSHEET H-4
PART II

		CAP REL BLDGS & FIXTURES (SQUARE FEET) 1	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT-ATION (MILEAGE) 4	RECONCIL-IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
	GENERAL SERVICE COST CENTER							
1	CAPITAL RELATED-BLDG & FIXT							1
2	CAPITAL RELATED-MOVABLE EQUIP							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION							4
5	ADMINISTRATIVE AND GENERAL					-81947	140357	5
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE						75464	6
7	PHYSICAL THERAPY						41280	7
8	OCCUPATIONAL THERAPY						19139	8
9	SPEECH PATHOLOGY						1836	9
10	MEDICAL SOCIAL SERVICES						150	10
11	HOME HEALTH AIDE						159	11
12	SUPPLIES						2329	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					-81947	140357	24
25	COST TO BE ALLOC (PER W/S H)						81947	25
26	UNIT COST MULTIPLIER						.583847	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				14960	360		364		1
2	SKILLED NURSING CARE	119523			16627					2
3	PHYSICAL THERAPY	65381			8890					3
4	OCCUPATIONAL THERAPY	30313								4
5	SPEECH PATHOLOGY	2908								5
6	MEDICAL SOCIAL SERVICES	238								6
7	HOME HEALTH AIDE	252			40					7
8	SUPPLIES	3689								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	222304			40517	360		364		20
21	UNIT COST MULTIPLIER									21

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

	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		15684	1391						1
2	SKILLED NURSING CARE		136150	12078						2
3	PHYSICAL THERAPY		74271	6589						3
4	OCCUPATIONAL THERAPY		30313	2689						4
5	SPEECH PATHOLOGY		2908	258						5
6	MEDICAL SOCIAL SERVICES		238	21						6
7	HOME HEALTH AIDE		292	26						7
8	SUPPLIES		3689	327						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		263545	23379						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					5398	22473		22473	1
2	SKILLED NURSING CARE						148228		148228	2
3	PHYSICAL THERAPY						80860		80860	3
4	OCCUPATIONAL THERAPY						33002		33002	4
5	SPEECH PATHOLOGY						3166		3166	5
6	MEDICAL SOCIAL SERVICES						259		259	6
7	HOME HEALTH AIDE						318		318	7
8	SUPPLIES						4016		4016	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					5398	292322		292322	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	12345	160673	2
3	PHYSICAL THERAPY	6734	87594	3
4	OCCUPATIONAL THERAPY	2748	35750	4
5	SPEECH PATHOLOGY	264	3430	5
6	MEDICAL SOCIAL SERVICES	22	281	6
7	HOME HEALTH AIDE	26	344	7
8	SUPPLIES	334	4350	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	22473	292322	20
21	UNIT COST MULTIPLIER	.083280		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			59032	2		4345			1
2	SKILLED NURSING CARE			65607						2
3	PHYSICAL THERAPY			35079						3
4	OCCUPATIONAL THERAPY									4
5	SPEECH PATHOLOGY									5
6	MEDICAL SOCIAL SERVICES									6
7	HOME HEALTH AIDE			159						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			159877	2		4345			20
21	TOTAL COST TO BE ALLOCATED			40517	360		364			21
22	UNIT COST MULTIPLIER			.253426						22
22	UNIT COST MULTIPLIER				180.000000		.083774			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 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	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION HOURS OF SERVICE 14	
1	ADMINISTRATIVE AND GENERAL		15684							1
2	SKILLED NURSING CARE		136150							2
3	PHYSICAL THERAPY		74271							3
4	OCCUPATIONAL THERAPY		30313							4
5	SPEECH PATHOLOGY		2908							5
6	MEDICAL SOCIAL SERVICES		238							6
7	HOME HEALTH AIDE		292							7
8	SUPPLIES		3689							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		263545							20
21	TOTAL COST TO BE ALLOCATED		23379							21
22	UNIT COST MULTIPLIER									22
22	UNIT COST MULTIPLIER		.088710							22

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

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUISITIO 15	PHARMACY COSTED REQUISITIO 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
1	ADMINISTRATIVE AND GENERAL				570	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				570	20
21	TOTAL COST TO BE ALLOCATED				5398	21
22	UNIT COST MULTIPLIER					22
22	UNIT COST MULTIPLIER				9.470175	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	160573		160573	487	329.72	1
2	PHYSICAL THERAPY	3	87594		87594	478	183.25	2
3	OCCUPATIONAL THERAPY	4	35750		35750	276	129.53	3
4	SPEECH PATHOLOGY	5	3430		3430	27	127.04	4
5	MEDICAL SOCIAL SERV	6	281		281			5
6	HOME HEALTH AIDE SERV	7	344		344	6	57.33	6
7	TOTAL		287972		287972	1274		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	4350		4350	2638	1.648976	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	282	104		92981	34291		127272	1
2 PHYSICAL THERAPY	262	123		48012	22540		70552	2
3 OCCUPATIONAL THERAPY	193	50		24999	6477		31476	3
4 SPEECH PATHOLOGY	18			2287			2287	4
5 MEDICAL SOCIAL SERV								5
6 HOME HEALTH AIDE SERV	6			344			344	6
7 TOTAL	761	277		168623	63308		231931	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	1087	1062			1792	1751			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	.582574			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	.105194			COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	56	.269066			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	183.25						1
2	OCCUPATIONAL THERAPY	3	129.53						2
3	SPEECH PATHOLOGY	4	127.04						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	121409	53144	10.01
10.02	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	348	1738	10.03
10.04	TOTAL PPS REIMBURSEMENT - PEP EPISODES	9679	2119	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	131436	57001	12
13	EXCESS REASONABLE COST			13
14	SUBTOTAL	131436	57001	14
15	COINSURANCE BILLED TO PROGRAM PATIENTS			15
16	NET COST	131436	57001	16
17	REIMBURSABLE BAD DEBTS			17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	131436	57001	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	131436	57001	22
23	SEQUESTRATION ADJUSTMENT			23
24	SUBTOTAL	131436	57001	24
25	TOTAL INTERIM PAYMENTS	131436	57001	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. 15-1I, 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				131436		57001	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				131436		57001	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				131436		57001	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

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

		HOSPITAL (14-1326) 1	HOSPITAL (14-1326) 1.01	SUB I	SUB II	SUB III	
	PART I - FULLY PROSPECTIVE METHOD						
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS						1
	CAPITAL FEDERAL AMOUNT						
2	CAPITAL DRG OTHER THAN OUTLIER						2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997						3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997						3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD						4
4.01	NUMBER OF INTERNS AND RESIDENTS FROM WORKSHEET S-3, PART I						4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						4.02
4.03	INDIRECT MEDICAL EDUCATON ADJUSTMENT						4.03
	DISPROPORTIONATE SHARE ADJUSTMENT						
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS						5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I						5.01
5.02	SUM OF LINES 5 AND 5.01						5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT						5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS						6
	PART II - HOLD HARMLESS METHOD						
1	NEW CAPITAL						1
2	OLD CAPITAL						2
3	TOTAL CAPITAL						3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL						4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE						5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT						6
7	REDUCED OLD CAPITAL AMOUNT						7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL						8
9	SUBTOTAL						9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)						10
	PART III - PAYMENT UNDER REASONABLE COST						
1	PROGRAM INPATIENT ROUTINE CAPITAL COST						1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST						2
3	TOTAL INPATIENT PROGRAM CAPITAL						3
4	CAPITAL COST PAYMENT FACTOR						4
5	TOTAL INPATIENT PROGRAM CAPITAL COST						5
	PART IV - COMPUTATION OF EXCEPTION PAYMENTS						
1	PROGRAM INPATIENT CAPITAL COSTS						1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES						2
3	NET PROGRAM INPATIENT CAPITAL COSTS						3
4	APPLICABLE EXCEPTION PERCENTAGE						4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS						5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES						6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES						7
8	CAPITAL MINIMUM PAYMENT LEVEL						8
9	CURRENT YEAR CAPITAL PAYMENTS						9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS						10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT						11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS						12
13	CURRENT YEAR EXCEPTION PAYMENT						13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD						14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)						15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)						16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT						17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-3
PART I

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
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 STORE						6.03
6.04	ADMITTING						6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE						6.05
6.06	OTHER ADMINISTRATIVE AND GENER						6.06
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
35	NURSING FACILITY						35
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY						53
55	MEDICAL SUPPLIES CHARGED TO PA						55
56	DRUGS CHARGED TO PATIENTS						56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RURAL HEALTH CLINIC						63.50
	OTHER REIMBURSABLE COST CENTERS						
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
94	OTHER SPECIAL PURPOSE COST CEN						94
94.01	INSURANCE AND MALPRACTICE						94.01
94.02	SUPPLIES AND EXPENSE						94.02
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
98	PHYSICIANS' PRIVATE OFFICES						98
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

RHC I
COMPONENT NO: 14-3477

WORKSHEET M-1

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

CHECK APPLICABLE BOX: [XX] RHC
[ ] FQHC

	COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	88141		88141		88141		88141	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	80123		80123		80123		80123	3
4 VISITING NURSE	45094		45094		45094		45094	4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9)	213358		213358		213358		213358	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		4701	4701		4701		4701	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)		4701	4701		4701		4701	21
22 TOTAL COSTS OF HEALTH CARE SERVICES	213358	4701	218059		218059		218059	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	95596	31076	126672		126672		126672	30
31 TOTAL FACILITY OVERHEAD	95596	31076	126672		126672		126672	31
32 TOTAL FACILITY COSTS	308954	35777	344731		344731		344731	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	0.37	1248	4200	1554		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	0.89	2183	2100	1869		3
4 SUBTOTAL	1.26	3431		3423	3431	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	1.26	3431			3431	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES	218059	10
11 TOTAL NONREIMBURSABLE COSTS		11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)	218059	12
13 RATIO OF RHC/FQHC SERVICES	1.000000	13
14 TOTAL FACILITY OVERHEAD	126672	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	778186	15
16 TOTAL OVERHEAD	904858	16
17 ALLOWABLE GME OVERHEAD		17
18 SUBTRACT LINE 17 FROM LINE 16	904858	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	904858	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1122917	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			1122917	1
2	COST OF VACCINES AND THEIR ADMINISTRATION			13544	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE			1109373	3
4	TOTAL VISITS			3431	4
5	PHYSICIANS VISITS UNDER AGREEMENT				5
6	TOTAL ADJUSTED VISITS			3431	6
7	ADJUSTED COST PER VISIT			323.34	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	323.34	323.34		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	588	589		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	190124	190447		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			380571	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			11138	17
18	NET PROGRAM COST EXCLUDING VACCINES			369433	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			295546	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			10156	20
21	TOTAL REIMBURSABLE PROGRAM COST			305702	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			305702	24
25	INTERIM PAYMENTS			132478	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			173224	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

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

RHC I
COMPONENT NO: 14-3477

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

		PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1	HEALTH CARE STAFF COSTS	213358	213358	213358	213358	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000238	0.002251	0.000491		2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	51	480	105		3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	557	1437			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	608	1917	105		5
6	TOTAL DIRECT COST OF THE FACILITY	218059	218059	218059	218059	6
7	TOTAL OVERHEAD	904858	904858	904858	904858	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.002788	0.008791	0.000482		8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	2523	7955	436		9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	3131	9872	541		10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	18	169	37		11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	173.94	58.41	14.62		12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	18	111	37	148	13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	3131	6484	541		14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		13544			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		10156			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				125047	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		7431	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		7431	3.99
4 TOTAL INTERIM PAYMENTS				132478	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
	PROVIDER TO PROGRAM	.50			5.50
		.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		173224	6.01
	PROVIDER TO PROGRAM	.02			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				305702	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	62.46		6.71				69.17	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	4.82	52.91	3.82	5.24			66.79	37
40	ANESTHESIOLOGY	8.03	27.18	6.87	9.55			51.63	40
41	RADIOLOGY-DIAGNOSTIC	12.02	27.00	1.99	19.09			60.10	41
44	LABORATORY	12.43	39.38	1.43	16.96			70.20	44
49	RESPIRATORY THERAPY	31.03	11.68	3.56	3.42			49.69	49
50	PHYSICAL THERAPY	7.79	34.04	0.30	12.64			54.77	50
53	ELECTROCARDIOLOGY	12.49	46.31	5.53	16.06			80.39	53
55	MEDICAL SUPPLIES CHARGED TO PAT	32.39	16.69	9.50	7.00			65.58	55
56	DRUGS CHARGED TO PATIENTS	35.96	17.18	3.88	15.16			72.18	56
61	EMERGENCY	0.05	37.89	0.04	27.78			65.76	61
62	OBSERVATION BEDS (NON-DISTINCT		47.01		26.45			73.46	62
101	TOTAL CHARGES	12.74	26.12	2.05	13.96			54.87	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS-BLDG & FIXT	1398831	10.25	-1398831	-21.13			3
4	NEW CAP REL COSTS-MVBLE EQUIP	584836	4.29	-584836	-8.83			4
5	EMPLOYEE BENEFITS	1638787	12.01	-1638787	-24.75			5
6.01	NONPATIENT TELEPHONES	24116	.18	-24116	-.36			6.01
6.02	DATA PROCESSING	79707	.58	-79707	-1.20			6.02
6.03	PURCHASING RECEIVING AND STORES	46777	.34	-46777	-.71			6.03
6.04	ADMITTING	126960	.93	-126960	-1.92			6.04
6.05	CASHIERING/ACCOUNTS RECEIVABLE	285532	2.09	-285532	-4.31			6.05
6.06	OTHER ADMINISTRATIVE AND GENERA	709309	5.20	-709309	-10.71			6.06
8	OPERATION OF PLANT	612866	4.49	-612866	-9.26			8
9	LAUNDRY & LINEN SERVICE	117187	.86	-117187	-1.77			9
10	HOUSEKEEPING	196999	1.44	-196999	-2.98			10
11	DIETARY	76806	.56	-76806	-1.16			11
12	CAFETERIA							12
14	NURSING ADMINISTRATION	286007	2.10	-286007	-4.32			14
15	CENTRAL SERVICES & SUPPLY	24883	.18	-24883	-.38			15
16	PHARMACY	188616	1.38	-188616	-2.85			16
17	MEDICAL RECORDS & LIBRARY	181325	1.33	-181325	-2.74			17
18	SOCIAL SERVICE	40833	.30	-40833	-.62			18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1218476	8.93	1874303	28.31	3092779	22.66	25
35	NURSING FACILITY	1679201	12.30	664101	10.03	2343302	17.17	35
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	171790	1.26	458371	6.92	630161	4.62	37
40	ANESTHESIOLOGY	256076	1.88	105435	1.59	361511	2.65	40
41	RADIOLOGY-DIAGNOSTIC	544770	3.99	478166	7.22	1022936	7.49	41
44	LABORATORY	828270	6.07	480295	7.25	1308565	9.59	44
49	RESPIRATORY THERAPY	150450	1.10	131011	1.98	281461	2.06	49
50	PHYSICAL THERAPY	423298	3.10	233255	3.52	656553	4.81	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	2725	.02	11271	.17	13996	.10	53
55	MEDICAL SUPPLIES CHARGED TO PAT	58608	.43	52844	.80	111452	.82	55
56	DRUGS CHARGED TO PATIENTS	251985	1.85	405597	6.13	657582	4.82	56
61	EMERGENCY	777351	5.70	670311	10.12	1447662	10.61	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	344731	2.53	778186	11.75	1122917	8.23	63.50
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY	222304	1.63	70018	1.06	292322	2.14	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	97927	.72	207213	3.13	305140	2.24	98

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	13648339	100.00	0	.00	13648339	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)	2181845
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)	5052585
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.432

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES	CLINIC NAME Hamilton Memorial Family Clinic	REPORTING PERIOD 14-3472 FROM: 7-1-09 TO: 6-30-10	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 14-3477	FROM 7-1-09 TO: 6-30-10	ATTACHMENT #2

	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSIFICATIONS 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	ENCOUNTERS OFF-SITE 4	ENCOUNTERS 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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES			CLINIC NAME Hamilton Memorial Family Clinic		REPORTING PERIOD 14-3422 FROM: 7-1-09 TO: 6-30-10		ATTACHMENT #1
COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL 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 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 14-3477 FROM 7-1-09 TO: 6-30-10

ATTACHMENT #2

	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSIFICATIONS 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	ENCOUNTERS OFF-SITE 4	ENCOUNTERS 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