HARDIN COUNTY GENERAL HOSPITAL

TITLE XVIII MEDICARE COST REPORT

PROVIDER NO. 14-1328

YEAR ENDED MARCH 31, 2010

August 10, 2010

National Government Services, Inc.
P.O. Box 2952
Milwaukee, WI 53201

Re: Provider: Hardin County General Hospital
Provider Numbers: 14-1328, 14-Z328, 14-3479
Period ended: 03/31/2010
Protested amounts claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Hardin County General Hospital, for the year ended March 31, 2010, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by National Government Services, Inc. The expenses in question relate to the Illinois State Medicaid Provider Tax Assessment in the amount of $120,044, which we have included as adjustments to line 6 (A&G) on worksheet A-8. We feel as though the tax should be, and is, allowed as a reimbursable cost under Medicare Guidelines and should remain on line 6 (A&G) for inclusion in the B-1 allocation process.

The calculation of the additional amounts due the provider was calculated by removing the adjustments on worksheet A-8. The expense was then allowed to be allocated by the B-1 accumulated cost statistic to the various Hospital departments. The protested amounts claimed for the period ended March 31, 2010, are as follows:

Worksheet E, part B, line 36	$ 18,432
Worksheet E-2, line 22	12,105
Worksheet E-3, part II, line 34	28,388
Worksheet M-3, line 27	4,818
Total	$ 63,743

Sincerely,

Roby Williams
Administrator
Hardin County General Hospital
6 Ferrell Road
Rosiclare, IL 62982
(217) 285-6634

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY 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; __ MANUALLY SUBMITTED COST REPORT — DATE: 08/25/2010 TIME: 15:25

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 HARDIN COUNTY GENERAL HOSPITAL (14-1328) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2009 AND ENDING 03/31/2010, 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: 08/25/2010 15:25
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(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		-404028	261237	321846	1
2	SUBPROVIDER I					2
3	SWING BED - SNF		247255			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			-66862		9
100	TOTAL		156773	194375	321846	100

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

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: FERRELL ROAD P.O.BOX: 2467 1
1.01 CITY: ROSICLARE STATE: IL ZIP CODE: 62982 COUNTY: HARDIN 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N- V XVIII	XIX	
	0	1	2	3	4 5	6	
2	HOSPITAL	HARDIN COUNTY GENERAL HOSPITAL	14-1328	07/09/2003	N O	O	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF	HARDIN COUNTY SWING BED	14-Z328	07/09/2003	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						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC	HARDIN COUNTY RHC	14-3479	04/03/2006	N O	N	14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 04/01/2009 TO: 03/31/2010 17
1 2

18 TYPE OF CONTROL 2 18

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1 19
20 SUBPROVIDER I 20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.			21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? 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	99914	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.			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.			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 1 & 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	07/09/2003		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02

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

28.03	STAFFING	0.00	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 1, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

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

MISCELLANEOUS COST REPORTING INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				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	N	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N				49
50	HOME HEALTH AGENCY	N	N				50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO	52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO	52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.		53
53.01	MDH PERIOD: BEGINNING: ENDING:		53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:		54
	PREMIUMS: 66800 PAID LOSSES: AND/OR SELF INSURANCE:		
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

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. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61

	COUNTY: 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)		NO				63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9125	53928.00		1634		396		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS SWING BED SNF					829				3
4	HOSPITAL ADULTS & PEDS SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9125	53928.00		2463		396		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	53928.00		2463		396		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					4584				24
25	TOTAL	25								25
26	OBSERVATION BED DAYS							94	3	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		2247								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		829								3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		45								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3121								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		3121						109.70		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		13333						15.53		24
25	TOTAL								141.23		25
26	OBSERVATION BED DAYS	91	405	16	389						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	DISCHARGES - TITLE XVIII 13	DISCHARGES - TITLE XIX 14	DISCHARGES - TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		427	101	608	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		427	101	608	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	5415258						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							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	686720						22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	145810	-842					24
25	LAUNDRY & LINEN SERVICE	52865						25
26	HOUSEKEEPING	108389	9149					26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	101519	-49744					27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA		49744					28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION		69590					30
31	CENTRAL SERVICES AND SUPPLY	27786	-20840					31
32	PHARMACY	179851						32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	248932	-20148					33
34	SOCIAL SERVICE	48742						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	5415258		5415258			1
2	EXCLUDED AREA SALARIES						2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5415258		5415258			3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS						5
6	TOTAL (SUM OF LINES 3 THRU 5)	5415258		5415258			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	1601114	18611	1619725			13

NHCMQ DEMONSTRATION STATISTICAL DATA WORKSHEET S-7
STATISTICAL DATA

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

RHC I WORKSHEET S 8
COMPONENT NO: 14 3479

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

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET:					1
1.01	CITY:	STATE:	ZIP CODE:	COUNTY:		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 (SPECIFY)		/ /	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? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)	NO	11

FACILITY HOURS OF OPERATIONS (1)

		SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	TYPE OPERATION 0	FROM 1	TO 2	FROM 3	TO 4	FROM 5	TO 6	FROM 7	TO 8	FROM 9	TO 10	FROM 11	TO 12	FROM 13	TO 14	
12	CLINIC			900	1700	900	1700	900	1700	900	1700	900	1700			12

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

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
3	0300	NEW CAP REL COSTS-BLDG & FIXT		16351	16351	31425	47776		47776	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		180833	180833	6373	187206		187206	4
5	0500	EMPLOYEE BENEFITS				70006	70006		70006	5
6	0600	ADMINISTRATIVE & GENERAL	686720	2019461	2706181	-64248	2641933	-945449	1696484	6
8	0800	OPERATION OF PLANT	145810	222272	368082	-1010	367072	-83	366989	8
9	0900	LAUNDRY & LINEN SERVICE	52865	15452	68317		68317		68317	9
10	1000	HOUSEKEEPING	108889	34734	143623	-10461	133162		133162	10
11	1100	DIETARY	101519	131662	233181	-99666	133515		133515	11
12	1200	CAFETERIA				98118	98118	-27268	70850	12
14	1400	NURSING ADMINISTRATION				79333	79333		79333	14
15	1500	CENTRAL SERVICES & SUPPLY	27786	8127	35913	-27709	8204		8204	15
16	1600	PHARMACY	179851	138372	318223	-67174	251049	-38260	212789	16
17	1700	MEDICAL RECORDS & LIBRARY	248932	59134	308066	-22641	285425	-1782	283643	17
18	1800	SOCIAL SERVICE	48742	13520	62262		62262		62262	18
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	1239663	436598	1676261	-273561	1402700	-100516	1302184	25
		ANCILLARY SERVICE COST CENTERS								
41	4100	RADIOLOGY-DIAGNOSTIC	403972	314968	718940	-9556	709384		709384	41
44	4400	LABORATORY	372695	695652	1068347	-5540	1062807	-100864	961943	44
49	4900	RESPIRATORY THERAPY	174505	85324	259829	-45475	214354	-32873	181481	49
50	5000	PHYSICAL THERAPY	71233	74971	146204	-144	146060		146060	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY	12639	1557	14196	32368	46564		46564	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT				141605	141605		141605	55
56	5600	DRUGS CHARGED TO PATIENTS				282948	282948		282948	56
		OUTPATIENT SERVICE COST CENTERS								
61	6100	EMERGENCY	790408	176844	967252	-88046	879206	-290481	588725	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RURAL HEALTH CLINIC	749029	170875	919904	40352	960256		960256	63.50
		OTHER REIMBURSABLE COST CENTERS								
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
88	8800	INTEREST EXPENSE		67297	67297	-67297				88
95		SUBTOTALS	5415258	4864004	10279262		10279262	-1537576	8741686	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
96.01	9601	VENDING MACHINE		16093	16093		16093		16093	96.01
101		TOTAL	5415258	4880097	10295355		10295355	-1537576	8757779	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS SUPPLY COST FROM CS	A	MEDICAL SUPPLIES CHARGED TO P	55	20840	6869	1
2	TO RECLASS DON COST	B	NURSING ADMINISTRATION	14	69590	9743	2
3	TO RECLASS COST TO CLINC	C	RURAL HEALTH CLINIC	63.50	30139	3973	3
4		C					4
5		C					5
6	TO RECLASS SUPPLY COST	D	MEDICAL SUPPLIES CHARGED TO P	55		113896	6
7		D					7
8		D					8
9		D					9
10		D					10
11		D					11
12		D					12
13	TO RECLASS INSURANCE EXPENSE	E	NEW CAP REL COSTS-BLDG & FIXT	3		3283	13
14		E	NEW CAP REL COSTS-MVBLE EQUIP	4		6373	14
15		E	EMPLOYEE BENEFITS	5		70006	15
16	TO RECLASS INTEREST	F	NEW CAP REL COSTS-BLDG & FIXT	3		28142	16
17		F	ADMINISTRATIVE & GENERAL	6		15414	17
18		F	RADIOLOGY DIAGNOSTIC	41		2194	18
19		F	ADULTS & PEDIATRICS	25		15427	19
20		F	RURAL HEALTH CLINIC	63.50		6360	20
21	TO RECLASS CAFE COST	G	CAFETERIA	12	49744	48374	21
22	TO RECLASS CARDIAC MONITORING COST	H	ELECTROCARDIOLOGY	53	26208	6165	22
23		H					23
24	TO RECLASS DRUG COST	I	DRUGS CHARGED TO PATIENTS	56		282948	24
25		I					25
26		I					26
27		I					27
28		I					28
29		I					29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				196521	618922	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	DECREASE COST CENTER	DECREASE LINE #	DECREASE SALARY	DECREASE OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS SUPPLY COST FROM CS	A	CENTRAL SERVICES & SUPPLY	15	20840	6869		1
2	TO RECLASS DON COST	B	ADULTS & PEDIATRICS	25	69590	9743		2
3	TO RECLASS COST TO CLINC	C	OPERATION OF PLANT	8	842	168		3
4		C	HOUSEKEEPING	10	9149	1312		4
5		C	MEDICAL RECORDS & LIBRARY	17	20148	2493		5
6	TO RECLASS SUPPLY COST	D	ADULTS & PEDIATRICS	25		50679		6
7		D	EMERGENCY	61		17216		7
8		D	RADIOLOGY-DIAGNOSTIC	41		11630		8
9		D	LABORATORY	44		5540		9
10		D	RESPIRATORY THERAPY	49		28753		10
11		D	PHYSICAL THERAPY	50		58		11
12		D	RADIOLOGY-DIAGNOSTIC	41		20		12
13	TO RECLASS INSURANCE EXPENSE	E					12	13
14		E					12	14
15		E	ADMINISTRATIVE & GENERAL	6		79662		15
16	TO RECLASS INTEREST	F					11	16
17		F						17
18		F						18
19		F						19
20		F	INTEREST EXPENSE	88		67297		20
21	TO RECLASS CAFE COST	G	DIETARY	11	49744	48374		21
22	TO RECLASS CARDIAC MONITORING COS	H						22
23		H	ADULTS & PEDIATRICS	25	26208	6160		23
24	TO RECLASS DRUG COST	I	ADULTS & PEDIATRICS	25		126588		24
25		I	EMERGENCY	61		70830		25
26		I	PHARMACY	16		67174		26
27		I	RESPIRATORY THERAPY	49		16722		27
28		I	PHYSICAL THERAPY	50		86		28
29		I	DIETARY	11		1548		29
30								30
31								31
32								32
33								33
34								34
35								35
36	TOTAL RECLASSIFICATIONS				196521	618922		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	17000					17000		1
2	LAND IMPROVEMENTS	100979					100979		2
3	BUILDINGS AND FIXTURES	1209909	331611		331611	160581	1380939		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT								5
6	MOVABLE EQUIPMENT	2311846	209925		209925		2521771		6
7	SUBTOTAL	3639734	541536		541536	160581	4020689		7
8	RECONCILING ITEMS								8
9	TOTAL	3639734	541536		541536	160581	4020689		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
	COMPUTATION OF RATIOS					ALLOCATION OF OTHER CAPITAL				
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	1481918		1481918	.370138					3
4	NEW CAP REL COSTS MVBLE EQUIP	2521771		2521771	.629862					4
5	TOTAL	4003689		4003689	1.000000					5

	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
	SUMMARY OF OLD AND NEW CAPITAL								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	16351		28142	3283			47776	3
4	NEW CAP REL COSTS-MVBLE EQUIP	180833			6373			187206	4
5	TOTAL	197184		28142	9656			234982	5

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

	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
	SUMMARY OF OLD AND NEW CAPITAL								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	16351						16351	3
4	NEW CAP REL COSTS-MVBLE EQUIP	180833						180833	4
5	TOTAL	197184						197184	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 / 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			NEW CAP REL COSTS BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES	B	-29196	ADMINISTRATIVE & GENERAL	6		7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-2937	ADMINISTRATIVE & GENERAL	6		9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-524734				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	-27268	CAFETERIA	12		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	A	1782	MEDICAL RECORDS & LIBRARY	17		20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						21
22	VENDING MACHINES						22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES						23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT						24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49		25
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50		26
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71		27
28	UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89		28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		32
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		33
34	PHYSICIANS' ASSISTANT						34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4		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							37
38							38
39							39
40							40
41							41
42	CMS APPEAL COST	A	-15721	ADMINISTRATIVE & GENERAL	6		42
43	BAD DEBT	A	-744004	ADMINISTRATIVE & GENERAL	6		43
44	LATE FEES	A	-28902	ADMINISTRATIVE & GENERAL	6		44
45	PHARMACY REBATES	B	-38260	PHARMACY	16		45
46	PROVIDER TAX	A	-120044	ADMINISTRATIVE & GENERAL	6		46
47	LOBBING PORTION OF DUES	A	-4645	ADMINISTRATIVE & GENERAL	6		47
48	RENTAL COST	A	-83	OPERATION OF PLANT	8		48
49							49
50	TOTAL		-1537576				50

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

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	PERCENT OF UNADJUSTED RCE LIMIT
	1	2		3	4	5	6	7	8	9
1	6	ADMINISTRATIVE & GENERAL	MED STAFF DIRECTOR	30085		30085				
2	25	ADULTS & PEDIATRICS	AGGREGATE	100516	100516					
3	44	LABORATORY	AGGREGATE	108074	100864	7210				
4	49	RESPIRATORY THERAPY	AGGREGATE	32873	32873					
5	61	EMERGENCY	AGGREGATE	569571	290481	279090				
101		TOTAL		841119	524734	316385				

PROVIDER BASED PHYSICIAN ADJUSTMENTS WORKSHEET A & T

	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
1	6	ADMINISTRATIVE & GENERAL	MED STAFF DIRECTOR							
2	25	ADULTS & PEDIATRICS	AGGREGATE							100516
3	44	LABORATORY	AGGREGATE							100864
4	49	RESPIRATORY THERAPY	AGGREGATE							32873
5	61	EMERGENCY	AGGREGATE							290481
101		TOTAL								524734

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

WORKSHEET A-8-4
PARTS I & II

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

PART I GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 35 HOURS PER WEEK	1820	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		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	5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		479.00				9
10	AHSEA		66.06				10
11	STANDARD TRAVEL ALLOWANCE	33.03	33.03				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	31643	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	31643	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	31643	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	66.06	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	31527	22
23	TOTAL SALARY EQUIVALENCY	31527	23

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

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

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

	STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	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	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	51527	57
58	TRAVEL ALLOWANCE AND EXPENSE PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	51527	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	28730	64
65	EXCESS OVER LIMITATION		65

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	28730	66
67	TOTAL COST	28730	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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		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	0.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINERS 5	
9	TOTAL HOURS WORKED		370.00				9
10	AHSEA		69.70				10
11	STANDARD TRAVEL ALLOWANCE	34.85	34.85				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	25789	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	25789	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	25789	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	69.70	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	54366	22
23	TOTAL SALARY EQUIVALENCY	54366	23

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

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

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

	STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	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	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

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

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

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

PART V OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	54366	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	54366	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	20204	64
65	EXCESS OVER LIMITATION		65

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	20204	66
67	TOTAL COST	20204	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A 8-4
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 16, 1998 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	45	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	675	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		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	5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		136.00				9
10	AHSEA		63.48				10
11	STANDARD TRAVEL ALLOWANCE	31.74	31.74				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	8633	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	8633	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	8633	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	63.48	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	42849	22
23	TOTAL SALARY EQUIVALENCY	42849	23

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

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

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

	STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS	24
25	ASSISTANTS	25
26	SUBTOTAL	26
27	STANDARD TRAVEL EXPENSE	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	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	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

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

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

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

[ ] OCCUPATIONAL [ ] 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	42849	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE		58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	42849	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	8132	64
65	EXCESS OVER LIMITATION		65

REASONABLE COST DETERMINATION FOR THERAPY SERVICES WORKSHEET A & A
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	8132	66
67	TOTAL COST	8132	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	47776	47776							3
4	NEW CAP REL COSTS-MVBLE EQUIP	187206		187206						4
5	EMPLOYEE BENEFITS	70006			70006					5
6	ADMINISTRATIVE & GENERAL	1696484	7783	30614	8878	1743759	1743759			6
8	OPERATION OF PLANT	366989	4737	18632	1874	392232	97513	489745		8
9	LAUNDRY & LINEN SERVICE	68317	2136	8401	683	79537	19774	29666	128977	9
10	HOUSEKEEPING	133162	74	292	1289	134817	33617	1030	4229	10
11	DIETARY	133515	2176	8561	669	144921	36029	30232	6489	11
12	CAFETERIA	70850	890	3500	643	75883	18865	12361		12
14	NURSING ADMINISTRATION	79333	4601	18100	900	102934	25590	63916		14
15	CENTRAL SERVICES & SUPPLY	8204			90	8294	2062			15
16	PHARMACY	212789	934	3675	2325	219723	54625	12979		16
17	MEDICAL RECORDS & LIBRARY	283643	2069	8138	2958	296808	73789	28739		17
18	SOCIAL SERVICE	62262	530	2086	630	65508	16286	7365		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1302184	10165	39987	14868	1367204	339905	141196	95117	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC	709384	3276	12886	5223	730769	181676	45503	2829	41
44	LABORATORY	961943	1261	4959	4818	972981	241893	17511		44
49	RESPIRATORY THERAPY	181481	934	3675	2256	188346	46825	12979		49
50	PHYSICAL THERAPY	146060	1817	7147	921	155945	38769	25237	11488	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	46564	234	919	421	48138	11968	3245		53
55	MEDICAL SUPPLIES CHARGED TO PAT	141605	940	3697	269	146511	36424	13056		55
56	DRUGS CHARGED TO PATIENTS	282948				282948	70344			56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	588725	2430	9560	10218	610933	151884	33760	8826	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC	960256			10073	970329	241233			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	8741686	46987	184829	70006	8738520	1738971	478775	128977	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		604	2377		2981	741	8395		96
96.01	VENDING MACHINE	16093	185			16278	4047	2575		96.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	8757779	47776	187206	70006	8757779	1743759	489745	128977	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B PART I

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10	11	12	14	15	16	17	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	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	173593								10
11	DIETARY	11433	229104							11
12	CAFETERIA	4674	113301	225084						12
14	NURSING ADMINISTRATION	24170		3551	220161					14
15	CENTRAL SERVICES & SUPPLY			570	5566	16492				15
16	PHARMACY	4908		6511		894	299640			16
17	MEDICAL RECORDS & LIBRARY	10868		19773		146		430123		17
18	SOCIAL SERVICE	2785		1754		37			93735	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	53395	115803	77950	214595	1138		340719	93735	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC	17207		22381		426		77883		41
44	LABORATORY	6622		22140		9607		11621		44
49	RESPIRATORY THERAPY	4908		9952		148				49
50	PHYSICAL THERAPY	9543		4735		145				50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	1227		3003		66				53
55	MEDICAL SUPPLIES CHARGED TO PAT	4937		1688		2872				55
56	DRUGS CHARGED TO PATIENTS						289559			56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	12767		17033		495				61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC			34043		519	10081			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	169444	229104	225084	220161	16492	299640	430123	93735	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN	3175								96
96.01	VENDING MACHINE	974								96.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	173593	229104	225084	220161	16492	299640	430123	93735	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		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	ADMINISTRATIVE & GENERAL				6
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	2840757		2840757	25
	ANCILLARY SERVICE COST CENTERS				
41	RADIOLOGY-DIAGNOSTIC	1078674		1078674	41
44	LABORATORY	1282275		1282275	44
49	RESPIRATORY THERAPY	263158		263158	49
50	PHYSICAL THERAPY	245862		245862	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	67646		67646	53
55	MEDICAL SUPPLIES CHARGED TO PAT	205488		205488	55
56	DRUGS CHARGED TO PATIENTS	642851		642851	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	836697		836697	61
62	OBSERVATION BEDS (NON DISTINCT				62
63.50	RURAL HEALTH CLINIC	1256205		1256205	63.50
	OTHER REIMBURSABLE COST CENTERS				
71	HOME HEALTH AGENCY				71
	SPECIAL PURPOSE COST CENTERS				
95	SUBTOTALS	8718613		8718613	95
	NONREIMBURSABLE COST CENTERS				
96	GIFT, FLOWER, COFFEE SHOP & CAN	15292		15292	96
96.01	VENDING MACHINE	23874		23874	96.01
101	CROSS FOOT ADJUSTMENTS				101
102	NEGATIVE COST CENTER				102
103	TOTAL	8757779		8757779	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP REL COSTS 3	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS TRATIVE & GENERAL 5	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE KEEPING 10	
	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	ADMINISTRATIVE & GENERAL		7783	30614	38397	38397				6
8	OPERATION OF PLANT		4737	18632	23369	2147	25516			8
9	LAUNDRY & LINEN SERVICE		2136	8401	10537	435	1546	12518		9
10	HOUSEKEEPING		74	292	366	738	54	410	1568	10
11	DIETARY		2176	8561	10737	793	1575	630	103	11
12	CAFETERIA		890	3500	4390	415	644		42	12
14	NURSING ADMINISTRATION		4601	18100	22701	563	3330		218	14
15	CENTRAL SERVICES & SUPPLY					45				15
16	PHARMACY		934	3675	4609	1203	676		44	16
17	MEDICAL RECORDS & LIBRARY		2069	8138	10207	1625	1497		98	17
18	SOCIAL SERVICE		530	2086	2616	359	384		25	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		10165	39987	50152	7487	7357	9231	484	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		3276	12886	16162	4050	2371	275	156	41
44	LABORATORY		1261	4959	6220	5326	912		60	44
49	RESPIRATORY THERAPY		934	3675	4609	1031	676		44	49
50	PHYSICAL THERAPY		1817	7147	8964	854	1316	1115	86	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		234	919	1153	264	169		11	53
55	MEDICAL SUPPLIES CHARGED TO PAT		940	3697	4637	802	680		45	55
56	DRUGS CHARGED TO PATIENTS					1549				56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		2430	9560	11990	3344	1759	857	115	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC					5312				63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS		46987	184829	231816	38292	24945	12518	1530	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		604	2377	2981	16	437		29	96
96.01	VENDING MACHINE		185		185	89	134		9	96.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		47776	187206	234982	38397	25516	12518	1568	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		11	12	14	15	16	17	18	25	
	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	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING									10
11	DIETARY	13838								11
12	CAFETERIA	6843	12334							12
14	NURSING ADMINISTRATION		195	27007						14
15	CENTRAL SERVICES & SUPPLY		31	683	759					15
16	PHARMACY		357		41	6930				16
17	MEDICAL RECORDS & LIBRARY		1083		7		14517			17
18	SOCIAL SERVICE		96		2			3482		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	6995	4274	26324	52		11499	3482	127337	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		1226		20		2629		26838	41
44	LABORATORY		1213		441		389		14561	44
49	RESPIRATORY THERAPY		545		7				6912	49
50	PHYSICAL THERAPY		259		7				12600	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		165		3				1765	53
55	MEDICAL SUPPLIES CHARGED TO PAT		92		132				6388	55
56	DRUGS CHARGED TO PATIENTS					6697			8246	56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		933		23				19021	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RURAL HEALTH CLINIC		1865		24	233			7434	63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	13838	12334	27007	759	6930	14517	3482	231102	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN								3463	96
96.01	VENDING MACHINE								417	96.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	13838	12334	27007	759	6930	14517	3482	234982	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	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	ADMINISTRATIVE & GENERAL			6
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		127337	25
	ANCILLARY SERVICE COST CENTERS			
41	RADIOLOGY-DIAGNOSTIC		26838	41
44	LABORATORY		14561	44
49	RESPIRATORY THERAPY		6912	49
50	PHYSICAL THERAPY		12600	50
51	OCCUPATIONAL THERAPY			51
52	SPEECH PATHOLOGY			52
53	ELECTROCARDIOLOGY		1765	53
55	MEDICAL SUPPLIES CHARGED TO PAT		6388	55
56	DRUGS CHARGED TO PATIENTS		8246	56
	OUTPATIENT SERVICE COST CENTERS			
61	EMERGENCY		19021	61
62	OBSERVATION BEDS (NON-DISTINCT			62
63.50	RURAL HEALTH CLINIC		7434	63.50
	OTHER REIMBURSABLE COST CENTERS			
71	HOME HEALTH AGENCY			71
	SPECIAL PURPOSE COST CENTERS			
95	SUBTOTALS		231102	95
	NONREIMBURSABLE COST CENTERS			
96	GIFT, FLOWER, COFFEE SHOP & CAN		3463	96
96.01	VENDING MACHINE		417	96.01
101	CROSS FOOT ADJUSTMENTS			101
102	NEGATIVE COST CENTER			102
103	TOTAL		234982	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	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	25771							3
4	NEW CAP REL COSTS-MVBLE EQUIP		25671						4
5	EMPLOYEE BENEFITS			5415258					5
6	ADMINISTRATIVE & GENERAL	4198	4198	686720	-1743759	7014020			6
8	OPERATION OF PLANT	2555	2555	144968		392232	19018		8
9	LAUNDRY & LINEN SERVICE	1152	1152	52865		79537	1152	186040	9
10	HOUSEKEEPING	40	40	99740		134817	40	6100	10
11	DIETARY	1174	1174	51775		144921	1174	9360	11
12	CAFETERIA	480	480	49744		75883	480		12
14	NURSING ADMINISTRATION	2482	2482	69590		102934	2482		14
15	CENTRAL SERVICES & SUPPLY			6946		8294			15
16	PHARMACY	504	504	179851		219723	504		16
17	MEDICAL RECORDS & LIBRARY	1116	1116	228784		296808	1116		17
18	SOCIAL SERVICE	286	286	48742		65508	286		18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	5483	5483	1150141		1367204	5483	137200	25
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC	1767	1767	403972		730769	1767	4080	41
44	LABORATORY	680	680	372695		972981	680		44
49	RESPIRATORY THERAPY	504	504	174505		188346	504		49
50	PHYSICAL THERAPY	980	980	71233		155945	980	16570	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	126	126	32571		48138	126		53
55	MEDICAL SUPPLIES CHARGED TO P	507	507	20840		146511	507		55
56	DRUGS CHARGED TO PATIENTS					282948			56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	1311	1311	790408		610933	1311	13730	61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RURAL HEALTH CLINIC			779168		970729			63.50
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
95	SUBTOTALS	25345	25345	5415258	1743759	6994761	18692	186040	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	326	326			2981	326		96
96.01	VENDING MACHINE	100				16278	100		96.01
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	47776	187206	70006		1743759	489745	128977	103
104	UNIT COST MULT-WS B PT I		7.292509				25.751656		104
104	UNIT COST MULT-WS B PT I	1.853867		.012928		.248610		.693276	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					38397	25516	12518	107
108	UNIT COST MULT-WS B PT III						1.341676		108
108	UNIT COST MULT WS B PT III					.005474		.067287	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA FTE'S SERVED 12	NURSING ADMINISTRATION DIRECT NRSING HRS 14	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE PATIENT DAYS 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	ADMINISTRATIVE & GENERAL									6
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	17826								10
11	DIETARY	1174	22518							11
12	CAFETERIA	480	11136	10268						12
14	NURSING ADMINISTRATION	2482		162	84877					14
15	CENTRAL SERVICES & SUPPLY			26	2146	654020				15
16	PHARMACY	504		297		35466	292799			16
17	MEDICAL RECORDS & LIBRARY	1116		902		5781		56000		17
18	SOCIAL SERVICE	286		80		1468			2247	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	5483	11382	3556	82731	45129		44360	2247	25
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC	1767		1021		16906		10140		41
44	LABORATORY	680		1010		380935		1500		44
49	RESPIRATORY THERAPY	504		454		5889				49
50	PHYSICAL THERAPY	980		216		5742				50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	126		137		2584				53
55	MEDICAL SUPPLIES CHARGED TO P	507		77		113896				55
56	DRUGS CHARGED TO PATIENTS						282948			56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	1311		777		19650				61
62	OBSERVATION BEDS (NON-DISTINC									62
63.50	RURAL HEALTH CLINIC			1553		20574	9851			63.50
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	17400	22518	10268	84877	654020	292799	56000	2247	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & C	326								96
96.01	VENDING MACHINE	100								96.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	173593	229104	225084	220161	16492	299640	430123	93735	103
104	UNIT COST MULT-WS B PT I	9.738191		21.920919		.025216		7.680768		104
104	UNIT COST MULT-WS B PT I		10.174261		2.593883		1.023364		41.715621	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	1568	13838	12334	27007	759	6930	14517	3482	107
108	UNIT COST MULT-WS B PT III	.087961		1.201208		.001161		.259232		108
108	UNIT COST MULT-WS B PT III		.614531		.318190		.023668		1.549622	108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	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	ADMINISTRATIVE & GENERAL	6
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
	ANCILLARY SERVICE COST CENTERS	
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	
71	HOME HEALTH AGENCY	71
	SPECIAL PURPOSE COST CENTERS	
95	SUBTOTALS	95
	NONREIMBURSABLE COST CENTERS	
96	GIFT, FLOWER, COFFEE SHOP & C	96
96.01	VENDING MACHINE	96.01
101	CROSS FOOT ADJUSTMENTS	101
102	NEGATIVE COST CENTER	102
103	COST TO BE ALLOC PER B PT I	103
104	UNIT COST MULT-WS B PT I	104
104	UNIT COST MULT-WS B PT I	104
105	COST TO BE ALLOC PER B PT II	105
106	UNIT COST MULT WS B PT II	106
106	UNIT COST MULT-WS B PT II	106
107	COST TO BE ALLOC PER B PT III	107
108	UNIT COST MULT-WS B PT III	108
108	UNIT COST MULT-WS B PT III	108

COMPUTATION OF RATIO OF COST TO CHARGES WORKSHEET C
PART I

	COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS	2840757					25
	ANCILLARY SERVICE COST CENTERS						
41	RADIOLOGY DIAGNOSTIC	1078674					41
44	LABORATORY	1282275					44
49	RESPIRATORY THERAPY	263158					49
50	PHYSICAL THERAPY	245862					50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	67646					53
55	MEDICAL SUPPLIES CHARGED TO	205488					55
56	DRUGS CHARGED TO PATIENTS	642851					56
	OUTPATIENT SERVICE COST CENTERS						
61	EMERGENCY	835697					61
62	OBSERVATION BEDS (NON-DIST)	329994		329994		329994	62
63.50	RURAL HEALTH CLINIC	1256205					63.50
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	9048607		329994		329994	101
102	LESS OBSERVATION BEDS	329994		329994		329994	102
103	TOTAL	8718613					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT 6	OUTPATIENT 7	TOTAL 8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1275234		1275234				25
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	399993	2061260	2461253	.438262			41
44	LABORATORY	596631	1928592	2525223	.507787			44
49	RESPIRATORY THERAPY	362751	292970	655721	.401326			49
50	PHYSICAL THERAPY	185261	696138	881399	.278945			50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	236046	154106	390151	.173384			53
55	MEDICAL SUPPLIES CHARGED TO	502631	170799	673430	.296336			55
56	DRUGS CHARGED TO PATIENTS	843922	516854	1360776	.460205			56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	36879	914449	951328	.878453			61
62	OBSERVATION BEDS (NON-DIST)	7632	185582	193214	1.707920	1.707920	1.707920	62
63.50	RURAL HEALTH CLINIC		1065060	1065060	1.179469			63.50
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	4456979	8025810	12482789				101
102	LESS OBSERVATION BEDS							102
103	TOTAL			12482789				103

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

CHECK APPLICABLE BOXES	[ ] TITLE V - O/P	[XX] HOSPITAL (14-1328)	[ ] 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							
41	RADIOLOGY-DIAGNOSTIC	.438262	.438262	.438262				41
44	LABORATORY	.507787	.507787	.507787				44
49	RESPIRATORY THERAPY	.401326	.401326	.401326				49
50	PHYSICAL THERAPY	.278945	.278945	.278945				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.173384	.173384	.173384				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.296336	.296336	.296336				55
56	DRUGS CHARGED TO PATIENTS	.462225	.462225	.462225				56
	OUTPATIENT SERVICE COST CENTERS							
61	EMERGENCY	.878453	.878453	.878453				61
62	OBSERVATION BEDS (NON-DISTINCT	1.707920	1.707920	1.707920				62
63.50	RURAL HEALTH CLINIC	1.179469	1.179469	1.179469				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	.462225	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

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

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1328)	[ ]	SNF	
APPLICABLE	[XX]	TITLE XVIII PT B	[ ]	SUB I	[ ]	NF	
BOXES	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ]	S/B-SNF	
			[ ]	SUB III	[ ]	S/B-NF	
			[ ]	SUB IV	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02	PROGRAM COST PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM COST 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									
41	RADIOLOGY-DIAGNOSTIC	593612								41
44	LABORATORY	1035313								44
49	RESPIRATORY THERAPY	35228								49
50	PHYSICAL THERAPY	145543								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	126305								53
55	MEDICAL SUPPLIES CHARGED TO PA	88868								55
56	DRUGS CHARGED TO PATIENTS	215760								56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY	263548								61
62	OBSERVATION BEDS (NON-DISTINCT	65096								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	2569273								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	2569273								104

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

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1328)	[ ]	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	ALL OTHER (COLS 1x4)	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01)	PROGRAM COST ALL OTHER (COLUMNS 1.01x5.02)	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.03	PROGRAM COST PPS SERVICES COLUMNS 1.01x5.04	HOSPITAL O/P PART B CHARGES (SEE INSTRU.)	HOSPITAL O/P PART B COST (COLUMNS 1.00x10	
		9	9.01	9.02	9.03	9.04	10	11	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC	260158							41
44	LABORATORY	525718							44
49	RESPIRATORY THERAPY	14138							49
50	PHYSICAL THERAPY	40598							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	21899							53
55	MEDICAL SUPPLIES CHARGED TO PAT	26335							55
56	DRUGS CHARGED TO PATIENTS	99730							56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY	231515							61
62	OBSERVATION BEDS (NON-DISTINCT	111179							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	1331270							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	1331270							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				127337	30476	96861	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				127337		96861	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	2652	395			36.52	14425	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	2652	395				14425	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
PART II

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1328)	[ ] SUB III	[ ] PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SUB IV	[ ] TEFRA
BOXES	[XX] TITLE XIX	[ ] SUB II	[XX] OTHER	

	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPATIENT PROGRAM CHARGES 4	OLD CAPITAL - RATIO OF COST TO CHARGES 5	OLD CAPITAL - CAPITAL COSTS 6	NEW CAPITAL - RATIO OF COST TO CHARGES 7	NEW CAPITAL - CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
41	RADIOLOGY-DIAGNOSTIC		26838	2461253				.010904		41
44	LABORATORY		14561	2525223				.005766		44
49	RESPIRATORY THERAPY		6912	655721				.010541		49
50	PHYSICAL THERAPY		12600	881399				.014295		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		1765	390151				.004524		53
55	MEDICAL SUPPLIES CHARGED TO P		6388	693430				.009212		55
56	DRUGS CHARGED TO PATIENTS		8246	1390776				.005929		56
	OUTPATIENT SERVICE COST CENTERS									
61	EMERGENCY		19021	951328				.019994		61
62	OBSERVATION BEDS (NON-DISTINC			193214						62
63.50	RURAL HEALTH CLINIC			1065060						63.50
	OTHER REIMBURSABLE COST CENTERS									
101	TOTAL		96331	10142495						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 COST'S 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					2652		395		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					2652		395		101

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

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1328)	[ ] SUB IV	[ ] PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SNF	[ ] TEFRA
BOXES	[XX] TITLE XIX	[ ] SUB II	[ ] NF	[ ] OTHER
		[ ] SUB III	[ ] ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS	
		1	1.01	2	2.01	2.02	2.03	3	
	ANCILLARY SERVICE COST CENTERS								
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 E PART IV

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1328)	[ ] SUB IV	[ ] PPS
APPLICABLE	[ ] TITLE XVIII PT A	[ ] SUB I	[ ] SNF	[ ] PEPPA
BOXES	[XX] TITLE XIX	[ ] SUB II	[ ] NF	[ ] OTHER
		[ ] SUB III	[ ] ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
41	RADIOLOGY-DIAGNOSTIC		2461253						41
44	LABORATORY		2525223						44
49	RESPIRATORY THERAPY		655721						49
50	PHYSICAL THERAPY		881399						50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY		390151						53
55	MEDICAL SUPPLIES CHARGED TO P		692430						55
56	DRUGS CHARGED TO PATIENTS		1390776						56
	OUTPATIENT SERVICE COST CENTERS								
61	EMERGENCY		951328						61
62	OBSERVATION BEDS (NON-DISTINC		193214						62
63.50	RURAL HEALTH CLINIC		1065060						63.50
	OTHER REIMBURSABLE COST CENTERS								
101	TOTAL		10142495						101

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

CHECK	[ ] TITLE V	[XX] HOSPITAL (14-1328)	[ ] SUB IV	[ ] PPS
APPLICABLE	[ ] TITLE XVIII-PT A	[ ] SUB I	[ ] SNF	[ ] TEFRA
BOXES	[XX] TITLE XIX	[ ] SUB II	[ ] NF	[ ] OTHER
		[ ] SUB III	[ ] ICF/MR	

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

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1 PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1328) 1	SUB 1 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)	3526						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2652						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2652						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	622						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	207						6
7	TOTAL SWING BED NF TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	34						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	11						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING BED AND NEWBORN DAYS)	1634						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	622						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	207						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

COMPOTATION 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) (14-1328)	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	98.38						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.38						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2840757						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	3345						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1082						25
26	TOTAL SWING-BED COST	679896						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2160861						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1275234						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI PRIVATE ROOM CHARGES (EXCLUDING SWING BED CHARGES)	1275234						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.694482						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI PRIVATE ROOM PER DIEM CHARGE	460.86						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	2160861						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) (14-1328)	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	814.80					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1331383					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1331383					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) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	716630					48
49	TOTAL PROGRAM INPATIENT COSTS	2048013					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) (14-1328) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	506806					60
61	MEDICARE SWING BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	168664					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	675470					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 II & IV

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

PART II SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

		SNF	
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) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	405					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	814.80					84
85 OBSERVATION BED COST	3.09994					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 (OTHER) (14-Y328) 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)	3526						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2652						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2652						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	622						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	207						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	34						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	11						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	395						9
10	SWING-BED SNF TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11	SWING-BED SNF TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12	SWING-BED NF TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D 1
PART I (CONT)

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

PART I - ALL PROVIDER COMPONENTS

		HOSPITAL (OTHER) (14-1328)	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	98.38						19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.38						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2840757						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	3345						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	1082						25
26	TOTAL SWING-BED COST	679896						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2160861						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1275234						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1275234						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.694482						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI PRIVATE ROOM PER DIEM CHARGE	480.86						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	2160861						37

COMPUTATION OF INPATIENT OPERATING COST WORKSHEET D-1
PART II

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

		HOSPITAL (OTHER) (14-1328)	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	814.80					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	321846					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	321846					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) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49	TOTAL PROGRAM INPATIENT COSTS	321846					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	14425					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST	14425					52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART II (CONT)

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

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	TARGET AMOUNT AND LIMITATION COMPUTATION	HOSPITAL (OTHER) (14-1328) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

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

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

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

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

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

		HOSPITAL (OTHER) (14-1328)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST							
83	TOTAL OBSERVATION BEDS	405					83
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	814.80					84
85	OBSERVATION BED COST	329994					85

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1328)	[ ] SNF	[ ] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		898500		25
	ANCILLARY SERVICE COST CENTERS				
41	RADIOLOGY-DIAGNOSTIC	.438262	232131	101734	41
44	LABORATORY	.507787	369478	187616	44
49	RESPIRATORY THERAPY	.401326	215329	86417	49
50	PHYSICAL THERAPY	.278945	24975	6967	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.173384	32354	5610	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.296336	277124	82122	55
56	DRUGS CHARGED TO PATIENTS	.462225	519312	240039	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.878453	6972	6125	61
62	OBSERVATION BEDS (NON DISTINCT	1.707920			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.179469			63.50
101	TOTAL		1677675	716630	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		1677675		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 (14-2328)	[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				
41	RADIOLOGY DIAGNOSTIC	.438262	19177	8405	41
44	LABORATORY	.507787	60672	30808	44
49	RESPIRATORY THERAPY	.401326	69765	27999	49
50	PHYSICAL THERAPY	.278945	142715	39810	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.173384	2091	363	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.296336	108292	32091	55
56	DRUGS CHARGED TO PATIENTS	.462225	112973	52219	56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.878453	5153	4527	61
62	OBSERVATION BEDS (NON-DISTINCT	1.707920	929	1587	62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.179469			63.50
101	TOTAL		521767	197809	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		521767		103

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (14-1328) [ ] SNF [ ] PPS
[ ] TITLE XVIII PT A [ ] SUB I [ ] NF [ ] TEFRA
[XX] TITLE XIX [ ] SUB II [ ] S/B-SNF [XX] OTHER
[ ] SUB III [ ] S/B-NF
[ ] SUB IV [ ] ICF/MR

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
42	RADIOLOGY-DIAGNOSTIC	.438262			42
44	LABORATORY	.507787			44
49	RESPIRATORY THERAPY	.401326			49
50	PHYSICAL THERAPY	.278945			50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.173384			53
55	MEDICAL SUPPLIES CHARGED TO PAT	.296336			55
56	DRUGS CHARGED TO PATIENTS	.462225			56
	OUTPATIENT SERVICE COST CENTERS				
61	EMERGENCY	.878453			61
62	OBSERVATION BEDS (NON-DISTINCT	1.707920			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RURAL HEALTH CLINIC	1.179469			63.50
101	TOTAL				101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES				103

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
	DRG AMOUNT						
1	OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02	OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03	PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04	PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05	PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06	ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07	PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08	SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2	OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01	OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997						2.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT						
3	BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01	NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02	INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06	ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [FOR CR PERIODS ENDING ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]						3.06
3.07	SUM OF LINES 3.04-3.06	0.00	0.00				3.07
3.08	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10	FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12	FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13	FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14	CURRENT YEAR ALLOWABLE FTE						3.14
3.15	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
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 [SUM OF LINES] [PLUS E-3,PT.VI] [3.21-3.23] [LINE 23]						3.23
3.24	SUM OF LINES 3.21-3.23	0	0				3.24
	DISPROPORTIONATE SHARE ADJUSTMENT						
4	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS						4
4.01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS						4.01
4.02	SUM OF 4 AND 4.01						4.02
4.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE						4.03
4.04	DISPROPORTIONATE SHARE ADJUSTMENT						4.04
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES						
5	TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317						5
5.01	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317						5.01
5.02	DIVIDE LINE 5.01 BY LINE 5						5.02
5.03	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317						5.03
5.04	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK						5.04
5.05	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS						5.05
5.06	TOTAL ADDITIONAL PAYMENT						5.06
6	SUBTOTAL						6
7	HOSPITAL SPECIFIC PAYMENTS						7
7.01	HOSPITAL SPECIFIC PAYMENTS (1996 HSR)						7.01
8	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS						8
9	PAYMENT FOR INPATIENT PROGRAM CAPITAL						9
10	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL						10
11	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT						11
11.01	NURSING AND ALLIED HEALTH MANAGED CARE						11.01
11.02	ADD-ON PAYMENT FOR NEW TECHNOLOGIES						11.02
12	NET ORGAN ACQUISITION COST						12
13	COST OF TEACHING PHYSICIANS						13
14	ROUTINE SERVICE OTHER PASS THROUGH COSTS						14
15	ANCILLARY SERVICE OTHER PASS THROUGH COSTS						15
16	TOTAL						16
17	PRIMARY PAYER PAYMENTS						17
18	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES						18
19	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES						19
20	COINSURANCE BILLED TO PROGRAM BENEFICIARIES						20
21	REIMBURSABLE BAD DEBTS						21
21.01	REDUCED PROGRAM REIMBURSABLE BAD DEBTS						21.01
21.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						21.02
22	SUBTOTAL						22

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E
PART A
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS (CONT)

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1328) 1	HOSPITAL (14-1328) 1.01	HOSPITAL (14-1328) 1.02	
1	MEDICAL AND OTHER SERVICES	1331270			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	1331270			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	1344583			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1328) 1	HOSPITAL (14-1328) 1.01	HOSPITAL (14-1328) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	17465			18
18.01	COINSURANCE	332571			18.01
19	SUBTOTAL	994547			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	994547			23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL	994547			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	108275			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	108275			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	98371			27.02
28	SUBTOTAL	1102822			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	1102822			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	841585			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	261237			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	18432			36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONCILIATION 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 WORKSHEET E-1
HOSPITAL (14-1328)

	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				1963282		881376	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	10/23/2009	167041			3.01
		PROGRAM TO	.02	03/05/2010	116333	03/05/2010	20123	3.02
			.03					3.03
		PROVIDER TO	.04					3.04
			.05					3.05
			.50			10/23/2009	54814	3.50
		PROVIDER TO	.51					3.51
			.52		NONE			3.52
		PROGRAM TO	.53					3.53
			.54					3.54
	SUBTOTAL		.99		283374		-39791	3.99
4	TOTAL INTERIM PAYMENTS				2246656		841585	4
		TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO	.01					5.01
			.02		NONE		NONE	5.02
		PROVIDER TO	.03					5.03
			.50					5.50
		PROVIDER TO	.51		NONE		NONE	5.51
		PROGRAM TO	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01				261237	6.01
		PROVIDER TO PROGRAM	.02		-404028			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				1842628		1102822	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-Z328)

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				694327			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
	PROGRAM TO	.02					3.02
	PROVIDER	.03		NONE		NONE	3.03
		.04					3.04
		.05					3.05
		.50	10/23/2009	84099			3.50
	PROVIDER TO	.51					3.51
	PROGRAM	.52				NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		84099			3.99
4 TOTAL INTERIM PAYMENTS				610228			4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO	.01					5.01
	PROVIDER	.02		NONE		NONE	5.02
		.03					5.03
	PROVIDER TO	.50					5.50
	PROGRAM	.51		NONE		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		247255			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				857483			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-Z328)	S/B SNF PART B (14-Z328)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		682225				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		199787				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		829				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		882012				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		882012				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		882012				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		35996				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		846016				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)		11467				17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		11467				17.01
18	TOTAL		857483				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		610228				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		247255				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		12105				22

CALCULATION OF REIMBURSEMENT SETTLEMENT WORKSHEET E-3
PART II

PART II MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1328)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	2048013						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	2048013						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	2068493						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 (14-1328)	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	2068493						19
20	DEDUCTIBLES	287723						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	1780770						22
23	COINSURANCE	7919						23
24	SUBTOTAL	1772851						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	69777						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	69777						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	64347						25.02
26	SUBTOTAL	1842628						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	1842628						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	2246656						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	-404028						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	28388						34

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

		TITLE V	TITLE XVIII		(XX) TITLE XIX			
		HOSPITAL (14 1328) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	321846						1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	321846						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	321846						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES							11
12	INTERNS AND RESIDENTS SERVICE CHARGES							12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE							13
14	TEACHING PHYSICIANS							14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION							15
16	TOTAL REASONABLE CHARGES							16
	CUSTOMARY CHARGES							
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							18
19	RATIO OF LINE 17 TO LINE 18							19
20	TOTAL CUSTOMARY CHARGES							20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							22
23	COST OF COVERED SERVICES	321846						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	321846						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31	321846						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

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

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

		HOSPITAL (14-1328; (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST							34
35	SUBTOTAL	321846						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	321846						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	321846						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	321846						55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM	321846						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	188843				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2572871				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-826395				6
7	INVENTORY	148853				7
8	PREPAID EXPENSES	12338				8
9	OTHER CURRENT ASSETS	77721				9
10	DUE FROM OTHER FUNDS	45075				10
11	TOTAL CURRENT ASSETS	2219306				11
	FIXED ASSETS					
12	LAND	17000				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	100979				13
13.01	ACCUMULATED DEPRECIATION	100979				13.01
14	BUILDINGS	1585939				14
14.01	ACCUMULATED DEPRECIATION	961362				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	2844113				18
18.01	ACCUMULATED DEPRECIATION	-2022249				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	1268421				21
	OTHER ASSETS					
22	INVESTMENTS					22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS					25
26	TOTAL OTHER ASSETS					26
27	TOTAL ASSETS	3487727				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1137915				28
29	SALARIES, WAGES & FEES PAYABLE	642156				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	465343				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES					35
36	TOTAL CURRENT LIABILITIES	2245414				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	887091				38
39	UNSECURED LOANS					39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66					40
41	OTHER LONG TERM LIABILITIES					41
42	TOTAL LONG TERM LIABILITIES	887091				42
43	TOTAL LIABILITIES	3132505				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	355222				44
45	SPECIFIC PURPOSE FUND BALANCE					45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED					46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED					47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL					48
49	PLANT FUND BALANCE - INVESTED IN PLANT					49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION					50
51	TOTAL FUND BALANCES	355222				51
52	TOTAL LIABILITIES AND FUND BALANCES	3487727				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	440766				1
2	NET INCOME (LOSS)	-85544				2
3	TOTAL	355222				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	355222				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	355222				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	1508200		1508200	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	401408		401408	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	1909608		1909608	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	1909608		1909608	16
17	ANCILLARY SERVICES	3299280	6053301	9352581	17
18	OUTPATIENT SERVICES	65191	2052658	2117849	18
18.60	RURAL HEALTH CLINIC		1065060	1065060	18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	5274079	9171019	14445098	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		10295355	26
27	ADD (SPECIFY)			27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS			33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		10295355	40

STATEMENT OF REVENUES AND EXPENSES WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	14445098	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	4404964	2
3	NET PATIENT REVENUES	10040134	3
4	LESS - TOTAL OPERATING EXPENSES	10295355	4
5	NET INCOME FROM SERVICE TO PATIENTS	-255221	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	10132	6
7	INCOME FROM INVESTMENTS	2268	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES	67456	11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	36080	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4020	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	11200	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	MISCELLANOUS	59	24
24.01	GRANTS	37908	24.01
25	TOTAL OTHER INCOME	169677	25
26	TOTAL	-85544	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-85544	31

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

	COST CENTER DESCRIPTION	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
3	NEW CAP REL COSTS BLDG & FIXT						3
4	NEW CAP REL COSTS MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
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
	ANCILLARY SERVICE COST CENTERS						
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						
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
96	GIFT, FLOWER, COFFEE SHOP & CA						96
96.01	VENDING MACHINE						96.01
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
106	UNIT COST MULTIPLIER						106

RHC I WORKSHEET M 1

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

COMPONENT NO: 14-3479

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	339228	40723	379951		379951		379951	1
2	PHYSICIAN ASSISTANT	78840	8440	87280		87280		87280	2
3	NURSE PRACTITIONER	83886	8167	92053		92053		92053	3
4	VISITING NURSE								4
5	OTHER NURSE	150173	29755	179928		179928		179928	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	96902	19008	115910		115910		115910	9
10	SUBTOTAL (SUM OF LINES 1-9)	749029	106093	855122		855122		855122	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		2368	2368		2368		2368	15
16	TRANSPORTATION (HEALTH CARE STAFF)		603	603		603		603	16
17	DEPRECIATION-MEDICAL EQUIPMENT		21509	21509		21509		21509	17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS		9851	9851		9851		9851	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)		34331	34331		34331		34331	21
22	TOTAL COSTS OF HEALTH CARE SERVICES	749029	140424	889453		889453		889453	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				40352	40352		40352	29
30	ADMINISTRATIVE COSTS		30451	30451		30451		30451	30
31	TOTAL FACILITY OVERHEAD		30451	30451	40352	70803		70803	31
32	TOTAL FACILITY COSTS	749029	170875	919904	40352	960256		960256	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3479

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	1.80	7626	4200	7560		1
2	PHYSICIAN ASSISTANTS	0.90	2744	2100	1890		2
3	NURSE PRACTITIONERS	0.90	2963	2100	1890		3
4	SUBTOTAL	3.60	13333		12340	13333	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	3.60	13333			13333	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	889453	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	889453	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD	70803	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	295949	15
16	TOTAL OVERHEAD	366752	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	366752	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	366752	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1256205	20

RHC I WORKSHEET M 3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14 3479

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	1256205	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	14510	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	1241695	3
4	TOTAL VISITS	13333	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	13333	6
7	ADJUSTED COST PER VISIT	93.13	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2	(SEE INSTR.) 3	
8	PER VISIT PAYMENT LIMIT	87.89	111.58		8
9	RATE FOR PROGRAM COVERED VISITS	93.13	93.13		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	3438	1146		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	320181	106727		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			426908	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			44861	17
18	NET PROGRAM COST EXCLUDING VACCINES			382047	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			305638	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			9127	20
21	TOTAL REIMBURSABLE PROGRAM COST			314765	21
22	REIMBURSABLE BAD DEBTS			11892	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			11475	22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			326657	24
25	INTERIM PAYMENTS			393519	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			66862	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			4818	27

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

RHC I

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3479

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	855122	855122	855122	855122	1
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000160	0.003040			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	137	2600			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	819	6716			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	956	9318			5
6	TOTAL DIRECT COST OF THE FACILITY	889453	889453	889453	889453	6
7	TOTAL OVERHEAD	366752	366752	366752	366752	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.001075	0.010476			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	394	3842			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	1350	13160			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	27	507			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	50.00	25.96			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	19	315			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	950	8177			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		14510			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		9127			16

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

RHC I
COMPONENT NO: 14-3479

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				359796	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		33723	3.01
		PROGRAM TO	.02			3.02
		PROVIDER	.03			3.03
			.04			3.04
			.05			3.05
			.50			3.50
		PROVIDER TO	.51			3.51
		PROGRAM	.52		NONE	3.52
			.53			3.53
			.54			3.54
	SUBTOTAL		.99		33723	3.99
4	TOTAL INTERIM PAYMENTS				393519	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO	.01			5.01
		PROVIDER	.02		NONE	5.02
			.03			5.03
		PROVIDER	.50			5.50
		TO	.51		NONE	5.51
		PROGRAM	.52			5.52
	SUBTOTAL		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02		-66862	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				326657	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	61.61		14.89				76.50	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
41	RADIOLOGY-DIAGNOSTIC	9.43	24.12					33.55	41
44	LABORATORY	14.63	41.00					55.63	44
49	RESPIRATORY THERAPY	32.84	5.37					38.21	49
50	PHYSICAL THERAPY	2.83	16.51					19.34	50
53	ELECTROCARDIOLOGY	8.29	32.37					40.66	53
55	MEDICAL SUPPLIES CHARGED TO PAT	39.96	12.82					52.78	55
56	DRUGS CHARGED TO PATIENTS	37.34	15.51					52.85	56
61	EMERGENCY	0.73	27.70					28.43	61
62	OBSERVATION BEDS (NON-DISTINCT		33.69					33.69	62
101	TOTAL CHARGES	13.44	20.58					34.02	101

	COST CENTER	DIRECT COSTS AMOUNT	%	ALLOCATED OVERHEAD AMOUNT	%	TOTAL COSTS AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
3	NEW CAP REL COSTS BLDG & FIXT	47776	.56	-47776	1.40			3
4	NEW CAP REL COSTS MVBLE EQUIP	187206	2.14	-187206	-5.47			4
5	EMPLOYEE BENEFITS	70006	.80	-70006	-2.05			5
6	ADMINISTRATIVE & GENERAL	1696484	19.37	-1696484	-49.60			6
8	OPERATION OF PLANT	366989	4.19	-366989	-10.73			8
9	LAUNDRY & LINEN SERVICE	68317	.78	-68317	-2.00			9
10	HOUSEKEEPING	133162	1.52	-133162	-3.89			10
11	DIETARY	133515	1.52	-133515	-3.90			11
12	CAFETERIA	70850	.81	-70850	2.07			12
14	NURSING ADMINISTRATION	79333	.91	-79333	-2.32			14
15	CENTRAL SERVICES & SUPPLY	8204	.09	-8204	-.24			15
16	PHARMACY	212789	2.43	212789	6.22			16
17	MEDICAL RECORDS & LIBRARY	283643	3.24	-283643	8.29			17
18	SOCIAL SERVICE	62262	.71	62262	1.82			18
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1302184	14.87	1538573	44.98	2840757	32.44	25
	ANCILLARY SERVICE COST CENTERS							
41	RADIOLOGY-DIAGNOSTIC	709384	8.10	369290	10.80	1078674	12.32	41
44	LABORATORY	961943	10.98	320332	9.36	1282275	14.64	44
49	RESPIRATORY THERAPY	181481	2.07	81677	2.39	263158	3.00	49
50	PHYSICAL THERAPY	146060	1.67	99802	2.92	245862	2.81	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	46564	.53	21082	.62	67646	.77	53
55	MEDICAL SUPPLIES CHARGED TO PAT	141605	1.62	63883	1.87	205488	2.35	55
56	DRUGS CHARGED TO PATIENTS	282948	3.23	359903	10.52	642851	7.34	56
61	EMERGENCY	588725	6.72	246972	7.22	835697	9.54	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RURAL HEALTH CLINIC	960256	10.96	295949	8.65	1256205	14.34	63.50
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			15292	.45	15292	.17	96
96.01	VENDING MACHINE	16093	.18	7781	.23	23874	.27	96.01
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	8759279	100.00	0	.00	8759279	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)	1290672
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)	2423730
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.533

RURAL HEALTH CENTER DENTAL STATISTICS		14-3479	CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD FROM: 1-Apr-09 TO: 31-Mar-10			ATTACHMENT #2
	COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	COL.1&2 3	RECLASSI-FICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3&4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL.5&6) 7
1	RHC DENTAL STAFF COST							
2	Dentists			-		-		-
3	Dental Hygienist		N/A	-		-		-
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)	HEALTH SERVICES HOURS	ENCOUNTERS		
				ON-SITE	OFF-SITE	TOTAL
		1	2	3	4	5
16	RHC DENTAL STAFF					
17	Dentists					0
18	Dental Hygienist					0
19						0
20						0
21	TOTAL - Dentists(Sum of lines 17 through 20)	0	0	0	0	0
22	Other - Dental Staff					0
23						0
24						0
25						0
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)	0	0	0	0	0
27	TOTAL - Dental Staff(Sum of lines 21 and 26)	0	0	0	0	0
28	Dental Services Under Agreement					0
29						0
30	TOTAL DENTAL(Sum of lines 27 through 29)	0	0	0	0	0

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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		14-3479	CLINIC NAME Hardin County Rural Health Clinic		REPORTING PERIOD FROM: 1-Apr-09 TO: 31-Mar-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			-		-		-
3	Patient Transportation		**N/A**	-		-		-
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.