HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT WORKSHEET S
CERTIFICATION AND SETTLEMENT SUMMARY PARTS I & II

INTERMEDIARY USE ONLY: [ ] AUDITED [ ] DESK REVIEWED DATE RECEIVED _____ INTERMEDIARY NO. _____ [ ] INITIAL [ ] FINAL [ ] RE-OPENING [XX] MCR CODE 1

PART I - CERTIFICATION

CHECK APPLICABLE BOX __ ELECTRONICALLY FILED COST REPORT __ MANUALLY SUBMITTED COST REPORT DATE: _____ TIME: _____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY HOOPESTON COMMUNITY MEMORIAL HOSPITAL (14-1316) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 10/01/2009 AND ENDING 09/30/2010, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) _____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
			PART A	PART B		
		1	2	3	4	
1	HOSPITAL		319344	219850	50180	1
2	SUBPROVIDER I					2
3	SWING BED - SNF		165369			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			66040		9
9.01	RURAL HEALTH CLINIC II			11884		9.01
9.02	RURAL HEALTH CLINIC III			-8500		9.02
100	TOTAL		484713	289274	50180	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: 701 EAST ORANGE P.O.BOX: 1
1.01 CITY: HOOPSETON STATE: IL ZIP CODE: 60942 COUNTY: VERMILLION 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	HOOPESTON COMMUNITY MEMORIAL HOSPI	14-1316	11/01/2001	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	HOOPESTON CMH SWING BED	14-Z316	11/01/2001	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF	HOOPESTON CMH SKILLED CARE	14-5470	11/01/2001	N	P	N	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	HOOPESTON MEDICAL CENTER RHC	14-3448	04/01/1998	N	O	N	14
14.01	HOSP-BASED RHC II	CISSNA PARK	14-3485	10/11/2006	N	O	N	14.01
14.02	HOSP-BASED RHC III	ROSSVILLE CLINIC	14-3496	10/01/2008	N	O	N	14.02
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 10/01/2009 TO: 09/30/2010		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.		NO			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.					21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	Y	16974	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2				21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2				21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.	NO				21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS).	NO	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.		NO			21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO				22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO				23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.					23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.					23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.					23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.					23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.					23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.					23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.					23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.					24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.					24.01

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

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	NO	NO		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)	NO	NO		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	11/01/2001		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.	NO			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	100	0.8320	0.8320	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.	2	14	14	28.02
	A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)				
28.03	STAFFING	0.00	NO		28.03
28.04	RECRUITMENT	0.00	NO		28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO		28.05
28.06	TRAINING	0.00	NO		28.06
28.07	OTHER (SPECIFY)		NO		28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO			30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	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: 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	22	8030	23735.00		690		62		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					731				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	22	8030	23735.00		1421		62		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	22	8030	23735.00		1421		62		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY	75	27375			498				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					3495				24
24.01	RHC II					406				24.01
24.02	RHC III					1000				24.02
25	TOTAL	97								25
26	OBSERVATION BED DAYS									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 PHYS 8	LESS I&R NON-ANES 9	NET	--FULL TIME EQUIV-- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		1128									1
2	HMO XIX											2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF		731									3
4	HOSPITAL ADULTS & PEDS - SWING BED NF		587									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		2446									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		2446							83.00		12
13	RPCH VISITS		19632									13
14	SUBPROVIDER I											14
15	SKILLED NURSING FACILITY		27165									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		16253							5.44		24
24.01	RHC II		1768							.83		24.01
24.02	RHC III		5396							1.00		24.02
25	TOTAL									90.27		25
26	OBSERVATION BED DAYS		110									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	DISCHARGES TITLE XVIII	DISCHARGES TITLE XIX	TOTAL ALL PATIENTS	
		12	13	14	15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		250	26	453	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		250	26	453	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
24.01	RHC II					24.01
24.02	RHC III					24.02
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	8167944	-147295		457419.00			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	1266311	-2164		89474.00			8
8.01	EXCLUDED AREA SALARIES	453350			41700.00			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)	1388814					CMS 339	13
14	WAGE RELATED COSTS (OTHER)						CMS 339	14
15	EXCLUDED AREAS	370376					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	92043			3523.00			21
22	ADMINISTRATIVE & GENERAL	980537	184832		47359.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT	168817			14118.00			24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING	252532			27172.00			26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	390085			37594.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	97030	-96181		20.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	224047	68629		14781.00			33
34	SOCIAL SERVICE	50346			3170.00			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	8167944	-147295	8020649	457419.00	17.53	1
2	EXCLUDED AREA SALARIES	1719661	-2164	1717497	131174.00	13.09	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	6448283	-145131	6303152	326245.00	19.32	3
4	SUBTOTAL OTHER WAGES & REL COSTS						4
5	SUBTOTAL WAGE-RELATED COSTS	1388814		1388814		22.03%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	7837097	-145131	7691966	326245.00	23.58	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	2255437	157280	2412717	147737.00	16.33	13

PROSPECTIVE PAYMENT FOR SNF WORKSHEET S-7
STATISTICAL DATA

	GROUP (1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1st RATE	SERVICES PRIOR TO OCTOBER 1st DAYS	SERVICES ON OR AFTER OCTOBER 1st RATE	SERVICES ON OR AFTER OCTOBER 1st DAYS	SERVICES THROUGH 4/1/2001 - 9/30/2001 RATE	SERVICES THROUGH 4/1/2001 - 9/30/2001 DAYS	SWING BED SNF DAYS	TOTAL	
	1	2	3	3.01	4	4.01	4.02	4.03	4.06	5	
1		RUC									1
2		RUB									2
3		RUA									3
3.01		RUX									3.01
3.02		RUL									3.02
4		RVC									4
5		RVB									5
6		RVA									6
6.01		RVX									6.01
6.02		RVL									6.02
7		RHC		102							7
8		RHB		97							8
9		RHA		62							9
9.01		RHX									9.01
9.02		RHL									9.02
10		RMC									10
11		RMB		2							11
12		RMA									12
12.01		RMX		47							12.01
12.02		RML		42							12.02
13		RLB									13
14		RLA									14
15		SE3		32							15
16		SE2		73							16
17		SE1		14							17
18		SSC									18
19		SSB									19
20		SSA		14							20
21		CC2									21
22		CC1									22
23		CB2									23
24		CB1		13							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		AAA									45
45.01		ES3									45.01
45.02		ES2									45.02
45.03		ES1									45.03
45.04		HE2									45.04
45.05		HE1									45.05
45.06		HD2									45.06
45.07		HD1									45.07
45.08		HC2									45.08
45.09		HC1									45.09
45.10		HB2									45.10
45.11		HB1									45.11
45.12		LE2									45.12
45.13		LE1									45.13
45.14		LD2									45.14
45.15		LD1									45.15
45.16		LC2									45.16
45.17		LC1									45.17
45.18		LB2									45.18
45.19		LB1									45.19
45.20		CE2									45.20
45.21		CE1									45.21
45.22		CD2									45.22
45.23		CD1									45.23
46		TOTAL		498							46

RHC I WORKSHEET S-8

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

COMPONENT NO: 14-3448

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 801 EAST ORANGE STREET 1

1.01 CITY: HOOPESTON STATE: IL ZIP CODE: 60452 COUNTY: VERMILLION 1.01

2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2	
3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6 APPALACHIAN REGIONAL COMMISSION		/ /	6
7 LOOK-ALIKES		/ /	7
8 OTHER		/ /	8

PHYSICIAN INFORMATION:	PHYSICIAN NAME	BILLING NO.	
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT			9

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

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION 0	SUNDAY FROM 1	SUNDAY TO 2	MONDAY FROM 3	MONDAY TO 4	TUESDAY FROM 5	TUESDAY TO 6	WEDNESDAY FROM 7	WEDNESDAY TO 8	THURSDAY FROM 9	THURSDAY TO 10	FRIDAY FROM 11	FRIDAY TO 12	SATURDAY FROM 13	SATURDAY TO 14	
12	CLINIC			830	1830	830	1830	830	1700	830	1700	830	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)? NO 14
IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.
LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

15 PROVIDER NAME: PROVIDER NUMBER: - 15
V XVIII XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

RHC II WORKSHEET S-8

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

COMPONENT NO: 14-3485

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 141 W GARFIELD AVE.	1
1.01	CITY: CISSNA PARK STATE: IL ZIP CODE: 60924 COUNTY: IRIQUOIS	1.01
2	DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	2

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 2	
3	COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/ /	3
4	MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /	4
5	HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/ /	5
6	APPALACHIAN REGIONAL COMMISSION		/ /	6
7	LOOK-ALIKES		/ /	7
8	OTHER		/ /	8

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NO.	
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT			9
		PHYSICIAN NAME	HOURS	
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD			10

11	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 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			830	1300	830	1300	830	1300	830	1300	830	1300			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

RHC III WORKSHEET S-8

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

COMPONENT NO: 14-3496

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: ROSSVILLE CLINIC					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		/ /	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)

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

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

13	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	NO	13
14	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? 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								
1	0100	OLD CAP REL COSTS-BLDG & FIXT								1
2	0200	OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300	NEW CAP REL COSTS-BLDG & FIXT				496688	496688	-7434	489254	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		1340530	1340530	107448	1447978		1447978	4
5	0500	EMPLOYEE BENEFITS	92043	1228901	1320944		1320944	-5045	1315899	5
6	0600	ADMINISTRATIVE & GENERAL	980537	2262605	3243142	-373346	2869796	-171132	2698664	6
7	0700	MAINTENANCE & REPAIRS								7
8	0800	OPERATION OF PLANT	168817	504908	673725	17686	691411		691411	8
9	0900	LAUNDRY & LINEN SERVICE		105297	105297		105297		105297	9
10	1000	HOUSEKEEPING	252532	48777	301309		301309		301309	10
11	1100	DIETARY	390085	357049	747134		747134	-70792	676342	11
12	1200	CAFETERIA								12
13	1300	MAINTENANCE OF PERSONNEL								13
14	1400	NURSING ADMINISTRATION	97030	8834	105864	-96181	9683		9683	14
15	1500	CENTRAL SERVICES & SUPPLY								15
16	1600	PHARMACY								16
17	1700	MEDICAL RECORDS & LIBRARY	224047	51467	275514	68629	344143	-4854	339289	17
18	1800	SOCIAL SERVICE	50346	4792	55138		55138		55138	18
20	2000	NONPHYSICIAN ANESTHETISTS								20
21	2100	NURSING SCHOOL								21
22	2200	I&R SERVICES-SALARY & FRINGES A								22
23	2300	I&R SERVICES-OTHER PRGM COSTS A								23
24	2400	PARAMED ED PRGM-(SPECIFY)								24
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	704878	88698	793576	1069	794645		794645	25
34	3400	SKILLED NURSING FACILITY	1266311	231527	1497838	33256	1531094		1531094	34
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	275565	1033317	1308882	-10423	1298459		1298459	37
40	4000	ANESTHESIOLOGY	147295	33853	181148		181148	-157999	23149	40
41	4100	RADIOLOGY-DIAGNOSTIC	412765	444294	857059		857059		857059	41
44	4400	LABORATORY	310083	416220	726303	-14007	712296		712296	44
46.30	4650	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900	RESPIRATORY THERAPY		58703	58703		58703		58703	49
50	5000	PHYSICAL THERAPY	69579	331190	400769		400769		400769	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
55	5500	MEDICAL SUPPLIES CHARGED TO PAT		288443	288443	-29999	258444		258444	55
55.30	5530	IMPL. DEV. CHARGED TO PATIENT								55.30
56	5600	DRUGS CHARGED TO PATIENTS	7682	619811	627493	-20939	606554		606554	56
59.97	3997	CARDIAC REHABILITATION								59.97
59.98	3998	HYPERBARIC OXYGEN THERAPY								59.98
59.99	3999	LITHOTRIPSY								59.99
		OUTPATIENT SERVICE COST CENTERS								
60	6000	CLINIC	92115	232860	324975	-551	324424		324424	60
61	6100	EMERGENCY	707427	1178225	1885652	-80513	1805139	-653348	1151791	61
62	6200	OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310	RHC	1094024	338758	1432782	-103279	1329503		1329503	63.50
63.51	6311	RHC II	157925	69536	227461	-24470	202991		202991	63.51
63.52	6312	RHC III	213508	71568	285076	-20714	264362		264362	63.52
63.60	6320	FQHC								63.60
		OTHER REIMBURSABLE COST CENTERS								
65	6500	AMBULANCE SERVICES	318230	97710	415940		415940		415940	65
69.10	6910	CMHC								69.10
69.20	6920	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930	OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940	OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
85.01	8510	PANCREAS ACQUISITION								85.01
85.02	8520	INTESTINAL ACQUISITION								85.02
85.03	8530	ISLET CELL ACQUISITION								85.03
95		SUBTOTALS	8032824	11447873	19480697	-49646	19431051	-1070604	18360447	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
99.01	9901	ASSISTED LIVING	135120	29187	164307	49646	213953		213953	99.01
100	7950	FOUNDATION								100
101		TOTAL	8167944	11477060	19645004		19645004	-1070604	18574400	101

RECLASSIFICATIONS WORKSHEET A-6
PAGE 1

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1	INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		592966	1
2							2
3							3
4	RENT EXPENSE	B	NEW CAP REL COSTS-MVBLE EQUIP	4		107448	4
5		B					5
6		B					6
7		B					7
8		B					8
9		B					9
10		B					10
11		B					11
12							12
13	CAPITAL INSURANCE	C	NEW CAP REL COSTS-BLDG & FIXT	3		28012	13
14							14
15		D					15
16	UTILITY EXPENSE	D	OPERATION OF PLANT	8		17686	16
17		D					17
18		D					18
19							19
20	ACTIVITIES THERAPY	E	ADULTS & PEDIATRICS	25	2164	281	20
21							21
22	INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	6		137394	22
23		F					23
24		F					24
25		F					25
26							26
27	CRNA SALARIES	G	ANESTHESIOLOGY	40		147295	27
28							28
29	DEPRECIATION EXPENSE	H	SKILLED NURSING FACILITY	34		45047	29
30		H	RHC	63.50		29597	30
31		H	ASSISTED LIVING	99.01		49646	31
32							32
33	ADMINISTRATIVE SALARIES	I	ADMINISTRATIVE & GENERAL	6	272078		33
34		I	MEDICAL RECORDS & LIBRARY	17	68629		34
35		I					35
36	SUBTOTAL				342871	1155372	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST EXPENSE	A	ADMINISTRATIVE & GENERAL	6		592966	11	1
2								2
3								3
4	RENT EXPENSE	B	ADMINISTRATIVE & GENERAL	6		30563	11	4
5		B	ADULTS & PEDIATRICS	25		1376		5
6		B	SKILLED NURSING FACILITY	34		47		6
7		B	OPERATING ROOM	37		10423		7
8		B	LABORATORY	44		14007		8
9		B	MEDICAL SUPPLIES CHARGED TO P	55		29999		9
10		B	DRUGS CHARGED TO PATIENTS	56		20939		10
11		B	EMERGENCY	61		94		11
12								12
13	CAPITAL INSURANCE	C	ADMINISTRATIVE & GENERAL	6		28012	11	13
14								14
15		D	ADMINISTRATIVE & GENERAL	6		7085		15
16	UTILITY EXPENSE	D	SKILLED NURSING FACILITY	34		9299		16
17		D	CLINIC	60		551		17
18		D	RHC	63.50		751		18
19								19
20	ACTIVITIES THERAPY	E	SKILLED NURSING FACILITY	34	2164	281		20
21								21
22	INSURANCE EXPENSE	F	EMERGENCY	61		80419		22
23		F	RHC	63.50		56138		23
24		F	RHC II	63.51		558		24
25		F	RHC III	63.52		279		25
26								26
27	CRNA SALARIES	G	ANESTHESIOLOGY	40	147295			27
28								28
29	DEPRECIATION EXPENSE	H	NEW CAP REL COSTS-BLDG & FIXT	3		124290	9	29
30		H						30
31		H						31
32								32
33	ADMINISTRATIVE SALARIES	I	NURSING ADMINISTRATION	14	96181			33
34		I	RHC	63.50	200179			34
35		I	RHC II	63.51	23912			35
36	SUBTOTAL				469731	1008077		36

RECLASSIFICATIONS WORKSHEET A-6
PAGE 2

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	INCREASE			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5	
1		I					1
2							2
3	RHC SPECIALTY PHYSICIAN	J	RHC	63.50	87246	36946	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				430117	1192318	36

RECLASSIFICATIONS WORKSHEET A-6

	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		I	RHC III	63.52	20435		1
2							2
3	RHC SPECIALTY PHYSICIAN	J	ADMINISTRATIVE & GENERAL	6	87246	36946	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				577412	1045023	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	191970	200000		200000		391970		1
2	LAND IMPROVEMENTS	72519					72519		2
3	BUILDINGS AND FIXTURES	10072044	246708		246708		10318752		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	284181	147297		147297		431478		5
6	MOVABLE EQUIPMENT	3703811	10720		10720		3714531		6
7	SUBTOTAL	14324525	604725		604725		14929250		7
8	RECONCILING ITEMS								8
9	TOTAL	14324525	604725		604725		14929250		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT	-131724		620978				489254	3
4	NEW CAP REL COSTS-MVBLE EQUIP	1340530		107448				1447978	4
5	TOTAL	1208806		728426				1937232	5

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

SUMMARY OF OLD AND NEW CAPITAL

	DESCRIPTION	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		9	10	11	12	13	14	15	
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP	1340530						1340530	4
5	TOTAL	1340530						1340530	5

ADJUSTMENTS TO EXPENSES WORKSHEET A-8

	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO.	WKST A-7 REF	
		1	2	3	4	5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3		3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4		4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-15594	NEW CAP REL COSTS-BLDG & FIXT	3	9	8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-653348				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	-49366	DIETARY	11		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19	SALE OF DRUGS TO OTHER THAN PATIENTS						19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4854	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	CATERING	B	-21426	DIETARY	11		37
38							38
39	LOBBYING EXPENSE	A	-3437	ADMINISTRATIVE & GENERAL	6		39
40						9	40
41	MARKETING SALARIES	A	-38134	ADMINISTRATIVE & GENERAL	6		41
42	MARKETING EXPENSE	A	-114090	ADMINISTRATIVE & GENERAL	6		42
43	MARKETING BENEFITS	A	-8213	ADMINISTRATIVE & GENERAL	6		43
44	MISCELLANEOUS REVENUE	B	-7258	ADMINISTRATIVE & GENERAL	6		44
45							45
46							46
47	CRNA SALARIES	A	-147295	ANESTHESIOLOGY	40		47
47.01	CRNA BENEFITS	A	-5045	EMPLOYEE BENEFITS	5		47.01
47.02	CRNA OTHER	A	-10704	ANESTHESIOLOGY	40		47.02
48							48
49							49
49.02	POB LAPSING SCHEDULE	A	8160	NEW CAP REL COSTS-BLDG & FIXT	3	9	49.02
50	TOTAL		-1070604				50

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

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

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

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

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

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

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

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERATION INCL FRINGES	PROFESSIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	PERCENT OF UNADJUSTED RCE LIMIT
	1	2		3	4	5	6	7	8	9
4	61	EMERGENCY	AGGREGATE	1005150	653348	351802				
101		TOTAL		1005150	653348	351802				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS WORKSHEET A-8-2

	WKST A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS-ALLOWANCE	ADJUST-MENT
	10	11		12	13	14	15	16	17	18
4	61	EMERGENCY	AGGREGATE							653348
101		TOTAL								653348

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

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	320	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	45	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		450.00	1533.00			9
10	AHSEA		71.23	53.43			10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			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	32054	15
16	ASSISTANTS	81908	16
17	SUBTOTAL ALLOWANCE AMOUNT	113962	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	113962	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	113962	23

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

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	11398	24
25	ASSISTANTS	1202	25
26	SUBTOTAL	12600	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	12600	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	12600	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	113962	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	12600	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	126562	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	92720	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	92720	66
67	TOTAL COST	92720	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 10, 1998 — PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	140	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	225	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		1837.00	1830.00	2375.00		9
10	AHSEA		71.23	53.43	35.62		10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62	26.72			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	130850	15
16	ASSISTANTS	97777	16
17	SUBTOTAL ALLOWANCE AMOUNT	228627	17
18	AIDES	84598	18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	313225	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES		21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES		22
23	TOTAL SALARY EQUIVALENCY	313225	23

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

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	4987	24
25	ASSISTANTS	6012	25
26	SUBTOTAL	10999	26
27	STANDARD TRAVEL EXPENSE		27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	10999	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	10999	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	313225	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	10999	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	324224	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	192559	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	192559	66
67	TOTAL COST	192559	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 10, 1998 — PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE		3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE		4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS		5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS		6
7	STANDARD TRAVEL EXPENSE RATE		7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		128.00				9
10	AHSEA		71.23				10
11	STANDARD TRAVEL ALLOWANCE	35.62	35.62				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	9117	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	9117	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	9117	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	71.23	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	55559	22
23	TOTAL SALARY EQUIVALENCY	55559	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	55559	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	55559	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	8033	64
65	EXCESS OVER LIMITATION		65

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	8033	66
67	TOTAL COST	8033	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									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT	489254	489254							3
4	NEW CAP REL COSTS-MVBLE EQUIP	1447978		1447978						4
5	EMPLOYEE BENEFITS	1315899			1315899					5
6	ADMINISTRATIVE & GENERAL	2698664	260970	772357	193415	3925406	3925406			6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT	691411	27666	81879	28018	828974	222135	1051109		8
9	LAUNDRY & LINEN SERVICE	105297	7872	23298		136467	36568	11705	184740	9
10	HOUSEKEEPING	301309	6286	18605	41912	368112	98641	9347		10
11	DIETARY	676342	24560	72688	64742	838332	224643	36520		11
12	CAFETERIA		3993	11817		15810	4237	5937		12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	9683	6504	19248	141	35576	9533	9670		14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	339289	7967	23578	48575	419409	112387	11846		17
18	SOCIAL SERVICE	55138	2841	8409	8356	74744	20029	4225		18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	794645	28459	84225	117347	1024676	274576	42316	62741	25
34	SKILLED NURSING FACILITY	1531094			209807	1740901	466501	399132	79777	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	1298459	14772	43719	45735	1402685	375869	21965		37
40	ANESTHESIOLOGY	23149				23149	6203			40
41	RADIOLOGY-DIAGNOSTIC	857059	33697	99730	68506	1058992	283772	50106		41
44	LABORATORY	712296	12488	36959	51464	813207	217910	18569		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	58703	4625	13688		77016	20638	6877		49
50	PHYSICAL THERAPY	400769	6315	18689	11548	437321	117186	9390	536	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT	258444	6834	20225		285503	76505	10161		55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS	606554	2369	7012	1275	617210	165390	3523		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	324424	6768	20030	15288	366510	98211	10063		60
61	EMERGENCY	1151791	15452	45730	117411	1330384	356495	22976		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	1329503			162831	1492334	399892	136141		63.50
63.51	RHC II	202991			22242	225233	60354			63.51
63.52	RHC III	264362			32044	296406	79426			63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES	415940			52816	468756	125610			65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	18360447	480438	1421886	1293473	18303113	3852711	820469	143054	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		8816	26092		34908	9354			96
99.01	ASSISTED LIVING	213953			22426	236379	63341	230640	41686	99.01
100	FOUNDATION									100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	18574400	489254	1447978	1315899	18574400	3925406	1051109	184740	103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		10	11	12	14	17	18	25	26	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	476100								10
11	DIETARY	16663	1116158							11
12	CAFETERIA	2709	197682	226375						12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION	4412			59191					14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY	5405		12004		561051				17
18	SOCIAL SERVICE	1928		2574			103500			18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	19308	58526	27830	21627	111485	19462	1662547		25
34	SKILLED NURSING FACILITY	182116	610138	72660	12805	32927	84038	3680995		34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	10022		10371	8383	37075		1866370		37
40	ANESTHESIOLOGY			1689				31041		40
41	RADIOLOGY-DIAGNOSTIC	22862		13628		88150		1517510		41
44	LABORATORY	8472		12678		62224		1133060		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY	3138				51853		159522		49
50	PHYSICAL THERAPY	4284		9082		27223		605022		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT	4636						376805		55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS	1607		2866				790596		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	4592		5183				484559		60
61	EMERGENCY	10483		28901	16376	108373		1873988		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	62118		18089		40445		2149019		63.50
63.51	RHC II							285587		63.51
63.52	RHC III							375832		63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES					1296		595662		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	364755	866346	217555	59191	561051	103500	17588115		95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN	5981						50243		96
99.01	ASSISTED LIVING	105364	249812	8820				936042		99.01
100	FOUNDATION									100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	476100	1116158	226375	59191	561051	103500	18574400		103

COST ALLOCATION - GENERAL SERVICE COSTS WORKSHEET B
PART I

	COST CENTER DESCRIPTION	TOTAL	
		27	
	GENERAL SERVICE COST CENTERS		
1	OLD CAP REL COSTS-BLDG & FIXT		1
2	OLD CAP REL COSTS-MVBLE EQUIP		2
3	NEW CAP REL COSTS-BLDG & FIXT		3
4	NEW CAP REL COSTS-MVBLE EQUIP		4
5	EMPLOYEE BENEFITS		5
6	ADMINISTRATIVE & GENERAL		6
7	MAINTENANCE & REPAIRS		7
8	OPERATION OF PLANT		8
9	LAUNDRY & LINEN SERVICE		9
10	HOUSEKEEPING		10
11	DIETARY		11
12	CAFETERIA		12
13	MAINTENANCE OF PERSONNEL		13
14	NURSING ADMINISTRATION		14
15	CENTRAL SERVICES & SUPPLY		15
16	PHARMACY		16
17	MEDICAL RECORDS & LIBRARY		17
18	SOCIAL SERVICE		18
20	NONPHYSICIAN ANESTHETISTS		20
21	NURSING SCHOOL		21
22	I&R SERVICES-SALARY & FRINGES A		22
23	I&R SERVICES-OTHER PRGM COSTS A		23
24	PARAMED ED PRGM-(SPECIFY)		24
	INPATIENT ROUTINE SERV COST CENTERS		
25	ADULTS & PEDIATRICS	1662547	25
34	SKILLED NURSING FACILITY	3680995	34
	ANCILLARY SERVICE COST CENTERS		
37	OPERATING ROOM	1866370	37
40	ANESTHESIOLOGY	31041	40
41	RADIOLOGY-DIAGNOSTIC	1517510	41
44	LABORATORY	1133060	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO		46.30
49	RESPIRATORY THERAPY	159522	49
50	PHYSICAL THERAPY	605022	50
51	OCCUPATIONAL THERAPY		51
52	SPEECH PATHOLOGY		52
55	MEDICAL SUPPLIES CHARGED TO PAT	376805	55
55.30	IMPL. DEV. CHARGED TO PATIENT		55.30
56	DRUGS CHARGED TO PATIENTS	790596	56
59.97	CARDIAC REHABILITATION		59.97
59.98	HYPERBARIC OXYGEN THERAPY		59.98
59.99	LITHOTRIPSY		59.99
	OUTPATIENT SERVICE COST CENTERS		
60	CLINIC	484559	60
61	EMERGENCY	1873988	61
62	OBSERVATION BEDS (NON-DISTINCT		62
63.50	RHC	2149019	63.50
63.51	RHC II	285587	63.51
63.52	RHC III	375832	63.52
63.60	FQHC		63.60
	OTHER REIMBURSABLE COST CENTERS		
65	AMBULANCE SERVICES	595662	65
69.10	CMHC		69.10
69.20	OUTPATIENT PHYSICAL THERAPY		69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY		69.30
69.40	OUTPATIENT SPEECH PATHOLOGY		69.40
71	HOME HEALTH AGENCY		71
	SPECIAL PURPOSE COST CENTERS		
85.01	PANCREAS ACQUISITION		85.01
85.02	INTESTINAL ACQUISITION		85.02
85.03	ISLET CELL ACQUISITION		85.03
95	SUBTOTALS	17588115	95
	NONREIMBURSABLE COST CENTERS		
96	GIFT, FLOWER, COFFEE SHOP & CAN	50243	96
99.01	ASSISTED LIVING	936042	99.01
100	FOUNDATION		100
101	CROSS FOOT ADJUSTMENTS		101
102	NEGATIVE COST CENTER		102
103	TOTAL	18574400	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL		260970	772357	1033327	1033327				6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		27666	81879	109545	58475	168020			8
9	LAUNDRY & LINEN SERVICE		7872	23298	31170	9626	1871	42667		9
10	HOUSEKEEPING		6286	18605	24891	25966	1494		52351	10
11	DIETARY		24560	72688	97248	59135	5838		1832	11
12	CAFETERIA		3993	11817	15810	1115	949		298	12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		6504	19248	25752	2509	1546		485	14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		7967	23578	31545	29585	1894		594	17
18	SOCIAL SERVICE		2841	8409	11250	5272	675		212	18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		28459	84225	112684	72280	6764	14490	2123	25
34	SKILLED NURSING FACILITY					122804	63802	18425	20024	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		14772	43719	58491	98944	3511		1102	37
40	ANESTHESIOLOGY					1633				40
41	RADIOLOGY-DIAGNOSTIC		33697	99730	133427	74700	8009		2514	41
44	LABORATORY		12488	36959	49447	57363	2968		932	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY		4625	13688	18313	5433	1099		345	49
50	PHYSICAL THERAPY		6315	18689	25004	30848	1501	124	471	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT		6834	20225	27059	20139	1624		510	55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS		2369	7012	9381	43537	563		177	56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC		6768	20030	26798	25853	1609		505	60
61	EMERGENCY		15452	45730	61182	93844	3673		1153	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC					105268	21762		6830	63.50
63.51	RHC II					15888				63.51
63.52	RHC III					20908				63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES					33066				65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS		480438	1421886	1902324	1014191	131152	33039	40107	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		8816	26092	34908	2462			658	96
99.01	ASSISTED LIVING					16674	36868	9628	11586	99.01
100	FOUNDATION									100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		489254	1447978	1937232	1033327	168020	42667	52351	103

ALLOCATION OF NEW CAPITAL RELATED COSTS WORKSHEET B PART III

	COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		11	12	14	17	18	25	26	27	
	GENERAL SERVICE COST CENTERS									
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING									10
11	DIETARY	164053								11
12	CAFETERIA	29055	47227							12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION			30292						14
15	CENTRAL SERVICES & SUPPLY									15
16	PHARMACY									16
17	MEDICAL RECORDS & LIBRARY		2504		66122					17
18	SOCIAL SERVICE		537			17946				18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	8602	5806	11068	13139	3374	250330		250330	25
34	SKILLED NURSING FACILITY	89679	15159	6553	3881	14572	354899		354899	34
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		2164	4290	4369		172871		172871	37
40	ANESTHESIOLOGY		352				1985		1985	40
41	RADIOLOGY-DIAGNOSTIC		2843		10389		231882		231882	41
44	LABORATORY		2645		7333		120688		120688	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY				6111		31301		31301	49
50	PHYSICAL THERAPY		1895		3208		63051		63051	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PAT						49332		49332	55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS		598				54256		54256	56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC		1081				55846		55846	60
61	EMERGENCY		6029	8381	12772		187034		187034	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC		3774		4767		142401		142401	63.50
63.51	RHC II						15888		15888	63.51
63.52	RHC III						20908		20908	63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES				153		33219		33219	65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	127336	45387	30292	66122	17946	1785891		1785891	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN						38028		38028	96
99.01	ASSISTED LIVING	36717	1840				113313		113313	99.01
100	FOUNDATION									100
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	164053	47227	30292	66122	17946	1937232		1937232	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	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	51833						3
4	NEW CAP REL COSTS-MVBLE EQUIP		51833					4
5	EMPLOYEE BENEFITS			7928606				5
6	ADMINISTRATIVE & GENERAL	27648	27648	1165369	-3925406	14648994		6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	2931	2931	168817		828974	74891	8
9	LAUNDRY & LINEN SERVICE	834	834			136467	834	9
10	HOUSEKEEPING	666	666	252532		368112	666	10
11	DIETARY	2602	2602	390085		838332	2602	11
12	CAFETERIA	423	423			15810	423	12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	689	689	849		35576	689	14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY	844	844	292676		419409	844	17
18	SOCIAL SERVICE	301	301	50346		74744	301	18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES							22
23	I&R SERVICES-OTHER PRGM COSTS							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	3015	3015	707042		1024676	3015	25
34	SKILLED NURSING FACILITY			1264147		1740901	28438	34
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	1565	1565	275565		1402685	1565	37
40	ANESTHESIOLOGY					23149		40
41	RADIOLOGY-DIAGNOSTIC	3570	3570	412765		1058992	3570	41
44	LABORATORY	1323	1323	310083		813207	1323	44
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY	490	490			77016	490	49
50	PHYSICAL THERAPY	669	669	69579		437321	669	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO P	724	724			285503	724	55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	251	251	7682		617210	251	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	717	717	92115		366510	717	60
61	EMERGENCY	1637	1637	707427		1330384	1637	61
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC			981091		1492334	9700	63.50
63.51	RHC II			134013		225233		63.51
63.52	RHC III			193073		296406		63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES			318230		468756		65
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERA							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
95	SUBTOTALS	50899	50899	7793486	-3925406	14377707	58458	95
	NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & C	934	934			34908		96
99.01	ASSISTED LIVING			135120		236379	16433	99.01
100	FOUNDATION							100

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	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	OPERATION OF PLANT SQUARE FEET 8	
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	COST TO BE ALLOC PER B PT I	489254	1447978	1315899		3925406	1051109	103
104	UNIT COST MULT-WS B PT I		27.935447				14.035184	104
104	UNIT COST MULT-WS B PT I	9.439045		.165969		.267964		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					1033327	168020	107
108	UNIT COST MULT-WS B PT III						2.243527	108
108	UNIT COST MULT-WS B PT III					.070539		108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 17	SOCIAL SERVICE TIME SPENT 18	
	GENERAL SERVICE COST CENTERS								
1	OLD CAP REL COSTS-BLDG & FIXT								1
2	OLD CAP REL COSTS-MVBLE EQUIP								2
3	NEW CAP REL COSTS-BLDG & FIXT								3
4	NEW CAP REL COSTS-MVBLE EQUIP								4
5	EMPLOYEE BENEFITS								5
6	ADMINISTRATIVE & GENERAL								6
7	MAINTENANCE & REPAIRS								7
8	OPERATION OF PLANT								8
9	LAUNDRY & LINEN SERVICE	243525							9
10	HOUSEKEEPING		74345						10
11	DIETARY		2602	140992					11
12	CAFETERIA		423	24971	278756				12
13	MAINTENANCE OF PERSONNEL								13
14	NURSING ADMINISTRATION		689			62891			14
15	CENTRAL SERVICES & SUPPLY								15
16	PHARMACY								16
17	MEDICAL RECORDS & LIBRARY		844		14781		10820		17
18	SOCIAL SERVICE		301		3170			117	18
20	NONPHYSICIAN ANESTHETISTS								20
21	NURSING SCHOOL								21
22	I&R SERVICES-SALARY & FRINGES								22
23	I&R SERVICES-OTHER PRGM COSTS								23
24	PARAMED ED PRGM-(SPECIFY)								24
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	82705	3015	7393	34269	22979	2150	22	25
34	SKILLED NURSING FACILITY	105164	28438	77072	89474	13605	635	95	34
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		1565		12771	8907	715		37
40	ANESTHESIOLOGY				2080				40
41	RADIOLOGY-DIAGNOSTIC		3570		16782		1700		41
44	LABORATORY		1323		15611		1200		44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		490				1000		49
50	PHYSICAL THERAPY	706	669		11183		525		50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P		724						55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS		251		3529				56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC		717		6382				60
61	EMERGENCY		1637		35588	17400	2090		61
62	OBSERVATION BEDS (NON-DISTINC								62
63.50	RHC		9700		22275		780		63.50
63.51	RHC II								63.51
63.52	RHC III								63.52
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES						25		65
69.10	CMHC								69.10
69.20	OUTPATIENT PHYSICAL THERAPY								69.20
69.30	OUTPATIENT OCCUPATIONAL THERA								69.30
69.40	OUTPATIENT SPEECH PATHOLOGY								69.40
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
85.01	PANCREAS ACQUISITION								85.01
85.02	INTESTINAL ACQUISITION								85.02
85.03	ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	188575	56958	109436	267895	62891	10820	117	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C		934						96
99.01	ASSISTED LIVING	54950	16453	31556	10861				99.01
100	FOUNDATION								100

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING SQUARE FEET 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION DIRECT NRSING HRS 14	MEDICAL RECORDS & LIBRARY GROSS REVENUE 17	SOCIAL SERVICE TIME SPENT 18	
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	184740	476100	1116158	226375	59191	561051	103500	103
104	UNIT COST MULT-WS B PT I	.758608		7.916463		.941168		884.615385	104
104	UNIT COST MULT-WS B PT I		6.403928		.812090		51.853142		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	42667	52351	164053	47227	30292	66122	17946	107
108	UNIT COST MULT-WS B PT III	.175206		1.163562		.481659		153.384615	108
108	UNIT COST MULT-WS B PT III		.704163		.169421		6.111091		108

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
	GENERAL SERVICE COST CENTERS	
1	OLD CAP REL COSTS-BLDG & FIXT	1
2	OLD CAP REL COSTS-MVBLE EQUIP	2
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
7	MAINTENANCE & REPAIRS	7
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
13	MAINTENANCE OF PERSONNEL	13
14	NURSING ADMINISTRATION	14
15	CENTRAL SERVICES & SUPPLY	15
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
20	NONPHYSICIAN ANESTHETISTS	20
21	NURSING SCHOOL	21
22	I&R SERVICES-SALARY & FRINGES	22
23	I&R SERVICES-OTHER PRGM COSTS	23
24	PARAMED ED PRGM-(SPECIFY)	24
	INPATIENT ROUTINE SERV COST CENTERS	
25	ADULTS & PEDIATRICS	25
34	SKILLED NURSING FACILITY	34
	ANCILLARY SERVICE COST CENTERS	
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
46.30	BLOOD CLOTTING FACTORS ADMIN	46.30
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
55	MEDICAL SUPPLIES CHARGED TO P	55
55.30	IMPL. DEV. CHARGED TO PATIENT	55.30
56	DRUGS CHARGED TO PATIENTS	56
59.97	CARDIAC REHABILITATION	59.97
59.98	HYPERBARIC OXYGEN THERAPY	59.98
59.99	LITHOTRIPSY	59.99
	OUTPATIENT SERVICE COST CENTERS	
60	CLINIC	60
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
63.50	RHC	63.50
63.51	RHC II	63.51
63.52	RHC III	63.52
63.60	FQHC	63.60
	OTHER REIMBURSABLE COST CENTERS	
65	AMBULANCE SERVICES	65
69.10	CMHC	69.10
69.20	OUTPATIENT PHYSICAL THERAPY	69.20
69.30	OUTPATIENT OCCUPATIONAL THERA	69.30
69.40	OUTPATIENT SPEECH PATHOLOGY	69.40
71	HOME HEALTH AGENCY	71
	SPECIAL PURPOSE COST CENTERS	
85.01	PANCREAS ACQUISITION	85.01
85.02	INTESTINAL ACQUISITION	85.02
85.03	ISLET CELL ACQUISITION	85.03
95	SUBTOTALS	95
	NONREIMBURSABLE COST CENTERS	
96	GIFT, FLOWER, COFFEE SHOP & C	96
99.01	ASSISTED LIVING	99.01
100	FOUNDATION	100

COST ALLOCATION - STATISTICAL BASIS WORKSHEET B-1

	COST CENTER DESCRIPTION	
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	1662547		1662547		1662547	25
34	SKILLED NURSING FACILITY	3680995		3680995		3680995	34
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	1866370		1866370		1866370	37
40	ANESTHESIOLOGY	31041		31041		31041	40
41	RADIOLOGY-DIAGNOSTIC	1517510		1517510		1517510	41
44	LABORATORY	1133060		1133060		1133060	44
46.30	BLOOD CLOTTING FACTORS ADMI						46.30
49	RESPIRATORY THERAPY	159522		159522		159522	49
50	PHYSICAL THERAPY	605022		605022		605022	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO	376805		376805		376805	55
55.30	IMPL. DEV. CHARGED TO PATIE						55.30
56	DRUGS CHARGED TO PATIENTS	790596		790596		790596	56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC	484559		484559		484559	60
61	EMERGENCY	1873988		1873988		1873988	61
62	OBSERVATION BEDS (NON-DISTI	89030		89030		89030	62
63.50	RHC	2149019		2149019		2149019	63.50
63.51	RHC II	285587		285587		285587	63.51
63.52	RHC III	375832		375832		375832	63.52
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES	595662		595662		595662	65
101	SUBTOTAL	17677145		17677145		17677145	101
102	LESS OBSERVATION BEDS	89030		89030		89030	102
103	TOTAL	17588115		17588115		17588115	103

COMPUTATION OF RATIO OF COST TO CHARGES — WORKSHEET C PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT	CHARGES OUTPATIENT	CHARGES TOTAL	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1630862		1630862				25
34	SKILLED NURSING FACILITY	5105700		5105700				34
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	958520	4067375	5025895	.371351	.371351	.371351	37
40	ANESTHESIOLOGY	8002	1443849	1451851	.021380	.021380	.021380	40
41	RADIOLOGY-DIAGNOSTIC	374708	6397114	6771822	.224092	.224092	.224092	41
44	LABORATORY	788145	4971182	5759327	.196735	.196735	.196735	44
46.30	BLOOD CLOTTING FACTORS ADMI							46.30
49	RESPIRATORY THERAPY	446915	1096450	1543365	.103360	.103360	.103360	49
50	PHYSICAL THERAPY	706213	916321	1622534	.372887	.372887	.372887	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO	772698	497814	1270512	.296577	.296577	.296577	55
55.30	IMPL. DEV. CHARGED TO PATIE							55.30
56	DRUGS CHARGED TO PATIENTS	889449	425500	1314949	.601237	.601237	.601237	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	316	188110	188426	2.571614	2.571614	2.571614	60
61	EMERGENCY	556147	6545349	7101496	.263886	.263886	.263886	61
62	OBSERVATION BEDS (NON-DISTI		284973	284973	.312416	.312416	.312416	62
63.50	RHC		1995211	1995211	1.077089	1.077089	1.077089	63.50
63.51	RHC II		225288	225288	1.267653	1.267653	1.267653	63.51
63.52	RHC III		526889	526889	.713304	.713304	.713304	63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES		1357020	1357020	.438949	.438949	.438949	65
101	SUBTOTAL	12237675	30938445	43176120				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	12237675	30938445	43176120				103

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

CHECK APPLICABLE BOXES	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1316)	[ ] SNF
	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ] NF
	[ ]	TITLE XIX - O/P	[ ]	SUB II	[ ] S/B-SNF
			[ ]	SUB III	[ ] S/B-NF
			[ ]	SUB IV	[ ] ICF/MR

	COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C, PART II COL. 8	PART I COL. 9	PART II COL. 9	PROGRAM CHARGES — OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC	
		1	1.01	1.02	2	3	4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.371351	.371351	.371351				37
40	ANESTHESIOLOGY	.021380	.021380	.021380				40
41	RADIOLOGY-DIAGNOSTIC	.224092	.224092	.224092				41
44	LABORATORY	.196735	.196735	.196735				44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	.103360	.103360	.103360				49
50	PHYSICAL THERAPY	.372887	.372887	.372887				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO PAT	.296577	.296577	.296577				55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	.601237	.601237	.601237				56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC	2.571614	2.571614	2.571614				60
61	EMERGENCY	.263886	.263886	.263886				61
62	OBSERVATION BEDS (NON-DISTINCT	.312416	.312416	.312416				62
63.50	RHC	1.077089	1.077089	1.077089				63.50
63.51	RHC II	1.267653	1.267653	1.267653				63.51
63.52	RHC III	.713304	.713304	.713304				63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	.438949	.438949	.438949				65
65.01	AMBULANCE SERVICES (2ND PERIOD)	.438949	.438949					65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.	.438949	.438949					65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.	.438949	.438949					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	.601237	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)	1778	2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)	1069	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 (14-1316)	[ ]	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	PPS SERVICES (SEE INSTRU.) 5.01	ALL OTHER (SEE INSTRU.) 5.02	PPS SERVICES (SEE INSTRU.) 5.03	PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	OUTPATIENT RADIOLOGY 7	OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	1710151								37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC	1780718								41
44	LABORATORY	1822919								44
46.30	BLOOD CLOTTING FACTORS ADMIN C									46.30
49	RESPIRATORY THERAPY	370560								49
50	PHYSICAL THERAPY	351731								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO PA	462093								55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS	342959								56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC	154750								60
61	EMERGENCY	1472805								61
62	OBSERVATION BEDS (NON-DISTINCT	139768								62
63.50	RHC									63.50
63.51	RHC II									63.51
63.52	RHC III									63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
65.01	AMBULANCE SERVICES (2ND PERIOD									65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56									65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56									65.03
101	SUBTOTAL	8608454								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	8608454								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK	[ ] TITLE V - O/P	[XX] HOSPITAL (14-1316)	[ ] SNF		
APPLICABLE	[XX] TITLE XVIII-PT B	[ ] SUB I	[ ] NF		
BOXES	[ ] TITLE XIX - O/P	[ ] SUB II	[ ] S/B-SNF		
		[ ] SUB III	[ ] S/B-NF		
		[ ] SUB IV	[ ] ICF/MR		

	COST CENTER DESCRIPTION	PROGRAM COST ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03	PPS SERVICES (COLUMNS 1.01x5.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.)	HOSPITAL I/P PART B COST (COLUMNS 1.02x10)	
		9	9.01	9.02	9.03	9.04	10	11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	635066							37
40	ANESTHESIOLOGY								40
41	RADIOLOGY-DIAGNOSTIC	399045							41
44	LABORATORY	358632							44
46.30	BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	RESPIRATORY THERAPY	38301							49
50	PHYSICAL THERAPY	131156							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO PAT	137046							55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS	206200							56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC	397957							60
61	EMERGENCY	388653							61
62	OBSERVATION BEDS (NON-DISTINCT	43666							62
63.50	RHC								63.50
63.51	RHC II								63.51
63.52	RHC III								63.52
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
65.01	AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02	AMBULANCE CHARGES (S-2 LINE 56.								65.02
65.03	AMBULANCE CHARGES (S-2 LINE 56.								65.03
101	SUBTOTAL	2735722							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	2735722							104

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV		[ ]	PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF	(14-5470)	[ ]	TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF			
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS
		1	1.01	2	2.01	2.02	2.03	3
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM							37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC							41
44	LABORATORY							44
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY							49
50	PHYSICAL THERAPY							50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO P							55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS							56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
61	EMERGENCY							61
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC							63.50
63.51	RHC II							63.51
63.52	RHC III							63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES							65
101	TOTAL							101

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV	[ ] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF (14-5470)	[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF	
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		5025895						37
40	ANESTHESIOLOGY		1451851						40
41	RADIOLOGY-DIAGNOSTIC		6771822			4360			41
44	LABORATORY		5759327			19984			44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		1543365			11952			49
50	PHYSICAL THERAPY		1622534			117754			50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P		1270512			29255			55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS		1314949			115866			56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC		188426						60
61	EMERGENCY		7101496						61
62	OBSERVATION BEDS (NON-DISTINC		284973						62
63.50	RHC		1995211						63.50
63.51	RHC II		225288						63.51
63.52	RHC III		526889						63.52
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL		32335150			299171			101

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

CHECK	[ ]	TITLE V	[ ]	HOSPITAL	[ ]	SUB IV	[ ] PPS
APPLICABLE	[XX]	TITLE XVIII-PT A	[ ]	SUB I	[XX]	SNF (14-5470)	[ ] TEFRA
BOXES	[ ]	TITLE XIX	[ ]	SUB II	[ ]	NF	
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO P						55
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.52	RHC III						63.52
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
101	TOTAL						101

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				250330	99460	150870	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				250330		150870	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	1238	62			121.87	7556	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	1238	62				7556	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS WORKSHEET D PART II

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	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	CAPITAL COSTS 6	---- NEW CAPITAL ---- RATIO OF COST TO CHARGES 7	CAPITAL COSTS 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		172871	5025895				.034396		37
40	ANESTHESIOLOGY		1985	1451851				.001367		40
41	RADIOLOGY-DIAGNOSTIC		231882	6771822				.034242		41
44	LABORATORY		120688	5759327				.020955		44
46.30	BLOOD CLOTTING FACTORS ADMIN									46.30
49	RESPIRATORY THERAPY		31301	1543365				.020281		49
50	PHYSICAL THERAPY		63051	1622534				.038860		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
55	MEDICAL SUPPLIES CHARGED TO P		49332	1270512				.038828		55
55.30	IMPL. DEV. CHARGED TO PATIENT									55.30
56	DRUGS CHARGED TO PATIENTS		54256	1314949				.041261		56
59.97	CARDIAC REHABILITATION									59.97
59.98	HYPERBARIC OXYGEN THERAPY									59.98
59.99	LITHOTRIPSY									59.99
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC		55846	188426				.296382		60
61	EMERGENCY		187034	7101496				.026337		61
62	OBSERVATION BEDS (NON-DISTINC			284973						62
63.50	RHC			1995211						63.50
63.51	RHC II			225288						63.51
63.52	RHC III			526889						63.52
63.60	FQHC									63.60
	OTHER REIMBURSABLE COST CENTERS									
65	AMBULANCE SERVICES									65
101	TOTAL		968246	32335150						101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS WORKSHEET D PART III

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

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8	
	INPAT ROUTINE SERV COST CTRS									
25	ADULTS & PEDIATRICS					1238		62		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					27165				34
35	NURSING FACILITY									35
101	TOTAL					28403		62		101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ]	PPS	
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA	
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER	
			[ ]	SUB III	[ ]	ICF/MR			

	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST	OUTPATIENT NONPHYSICIAN ANESTHETIST COST	MEDICAL EDUCATION COST	N/A	N/A	N/A	TOTAL COSTS
		1	1.01	2	2.01	2.02	2.03	3
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM							37
40	ANESTHESIOLOGY							40
41	RADIOLOGY-DIAGNOSTIC							41
44	LABORATORY							44
46.30	BLOOD CLOTTING FACTORS ADMIN							46.30
49	RESPIRATORY THERAPY							49
50	PHYSICAL THERAPY							50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO P							55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS							56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
61	EMERGENCY							61
62	OBSERVATION BEDS (NON-DISTINC							62
63.50	RHC							63.50
63.51	RHC II							63.51
63.52	RHC III							63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES							65
101	TOTAL							101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

	COST CENTER DESCRIPTION	OUTPATIENT PASS THROUGH COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	OUTPATIENT RATIO OF COST TO CHARGES 5.01	INPATIENT PROGRAM CHARGES 6	INPATIENT PROGRAM PASS THROUGH COSTS 7	OUTPATIENT PROGRAM CHARGES 8	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM		5025895						37
40	ANESTHESIOLOGY		1451851						40
41	RADIOLOGY-DIAGNOSTIC		6771822						41
44	LABORATORY		5759327						44
46.30	BLOOD CLOTTING FACTORS ADMIN								46.30
49	RESPIRATORY THERAPY		1543365						49
50	PHYSICAL THERAPY		1622534						50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
55	MEDICAL SUPPLIES CHARGED TO P		1270512						55
55.30	IMPL. DEV. CHARGED TO PATIENT								55.30
56	DRUGS CHARGED TO PATIENTS		1314949						56
59.97	CARDIAC REHABILITATION								59.97
59.98	HYPERBARIC OXYGEN THERAPY								59.98
59.99	LITHOTRIPSY								59.99
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC		188426						60
61	EMERGENCY		7101496						61
62	OBSERVATION BEDS (NON-DISTINC		284973						62
63.50	RHC		1995211						63.50
63.51	RHC II		225288						63.51
63.52	RHC III		526889						63.52
63.60	FQHC								63.60
	OTHER REIMBURSABLE COST CENTERS								
65	AMBULANCE SERVICES								65
101	TOTAL		32335150						101

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

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1316)	[ ]	SUB IV	[ ] PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ] TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ] OTHER
			[ ]	SUB III	[ ]	ICF/MR	

	COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02	
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO P						55
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINC						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.52	RHC III						63.52
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
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) (14-1316) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF (PPS) (14-5470) 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	2556					27165	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1238					27165	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1238					27165	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	569						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	184						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	403						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	690					498	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	162						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	569						11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15	TOTAL NURSERY DAYS							15
16	TITLE V OR XIX NURSERY DAYS							16

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

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

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF (PPS) (14-5470)	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.40						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1662547					3680995	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	21602						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	47312						25
26 TOTAL SWING-BED COST	660556						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1001991					3680995	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1648130					3403144	28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1648130					3403144	30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.607956					1.081645	31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1331.28					125.28	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	1001991					3680995	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) (14-1316)	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	809.36					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	558458					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	558458					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) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	610008					48
49	TOTAL PROGRAM INPATIENT COSTS	1168466					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) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	131116					60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	460526					61
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	591642					62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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

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

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

		SNF (PPS) (14-5470) 1	
66	SNF/NF/ICF/MR ROUTINE SERVICE COST	3680995	66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	135.51	67
68	PROGRAM ROUTINE SERVICE COST	67484	68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	67484	70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	354899	71
72	PER DIEM CAPITAL RELATED COSTS	13.06	72
73	PROGRAM CAPITAL RELATED COSTS	6504	73
74	INPATIENT ROUTINE SERVICE COST	60980	74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	60980	76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78	INPATIENT ROUTINE SERVICE COST LIMITATION		78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	67484	79
80	PROGRAM INPATIENT ANCILLARY SERVICES	128392	80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	195876	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) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	110					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	809.36					84
85 OBSERVATION BED COST	89030					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) (14-1316) 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)	2556						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	1238						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1238						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	162						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	569						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	184						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	403						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	62						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) (14-1316)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	117.40						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	117.40						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1662547						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	21602						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	47312						25
26 TOTAL SWING-BED COST	660556						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1001991						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1648130						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1648130						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.607956						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1331.28						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	1001991						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) (14-1316)	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	809.36					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	50180					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	50180					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) (14-1316) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST						48
49	TOTAL PROGRAM INPATIENT COSTS	50180					49
	PASS THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	7556					50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52	TOTAL PROGRAM EXCLUDABLE COST	7556					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) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58	BONUS PAYMENT						58
58.01	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03	IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04	RELIEF PAYMENT						58.04
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03	PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05	REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06	REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07	REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08

PROGRAM INPATIENT ROUTINE SWING BED COST

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

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

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

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

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

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

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

	HOSPITAL (OTHER) (14-1316)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	110					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	809.36					84
85 OBSERVATION BED COST	89030					85

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V	[XX] HOSPITAL (14-1316)	[ ] 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		984206		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.371351	335325	124523	37
40	ANESTHESIOLOGY	.021380			40
41	RADIOLOGY-DIAGNOSTIC	.224092	138173	30963	41
44	LABORATORY	.196735	345857	68042	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.103360	161478	16690	49
50	PHYSICAL THERAPY	.372887	44769	16694	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.296577	223595	66313	55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.601237	475312	285775	56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	2.571614			60
61	EMERGENCY	.263886	3819	1008	61
62	OBSERVATION BEDS (NON-DISTINCT	.312416			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.077089			63.50
63.51	RHC II	1.267653			63.51
63.52	RHC III	.713304			63.52
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		1728328	610008	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		1728328		103

INPATIENT ANCILLARY COST APPORTIONMENT — WORKSHEET D-4

[ ] TITLE V	[ ] HOSPITAL	[XX] SNF (14-5470)	[XX] PPS
[XX] TITLE XVIII-PT A	[ ] SUB I	[ ] NF	[ ] TEFRA
[ ] TITLE XIX	[ ] SUB II	[ ] S/B-SNF	[ ] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.371351			37
40	ANESTHESIOLOGY	.021380			40
41	RADIOLOGY-DIAGNOSTIC	.224092	4360	977	41
44	LABORATORY	.196735	19984	3932	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.103360	11952	1235	49
50	PHYSICAL THERAPY	.372887	117754	43909	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.296577	29255	8676	55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.601237	115866	69663	56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	2.571614			60
61	EMERGENCY	.263886			61
62	OBSERVATION BEDS (NON-DISTINCT	.312416			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.077089			63.50
63.51	RHC II	1.267653			63.51
63.52	RHC III	.713304			63.52
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		299171	128392	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		299171		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-Z316)	[XX] OTHER
	[ ] SUB III	[ ] S/B-NF	
	[ ] SUB IV	[ ] ICF/MR	

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.371351			37
40	ANESTHESIOLOGY	.021380			40
41	RADIOLOGY-DIAGNOSTIC	.224092	14060	3151	41
44	LABORATORY	.196735	58204	11451	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.103360	22679	2344	49
50	PHYSICAL THERAPY	.372887	272228	101510	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.296577	99654	29555	55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.601237	178955	107594	56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	2.571614			60
61	EMERGENCY	.263886			61
62	OBSERVATION BEDS (NON-DISTINCT	.312416			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.077089			63.50
63.51	RHC II	1.267653			63.51
63.52	RHC III	.713304			63.52
63.60	FQHC				63.60
65	AMBULANCE SERVICES				65
101	TOTAL		645780	255605	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		645780		103

INPATIENT ANCILLARY COST APPORTIONMENT WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (14-1316) [ ] 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				
37	OPERATING ROOM	.371351			37
40	ANESTHESIOLOGY	.021380			40
41	RADIOLOGY-DIAGNOSTIC	.224092			41
44	LABORATORY	.196735			44
46.30	BLOOD CLOTTING FACTORS ADMIN CO				46.30
49	RESPIRATORY THERAPY	.103360			49
50	PHYSICAL THERAPY	.372887			50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
55	MEDICAL SUPPLIES CHARGED TO PAT	.296577			55
55.30	IMPL. DEV. CHARGED TO PATIENT				55.30
56	DRUGS CHARGED TO PATIENTS	.601237			56
59.97	CARDIAC REHABILITATION				59.97
59.98	HYPERBARIC OXYGEN THERAPY				59.98
59.99	LITHOTRIPSY				59.99
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC	2.571614			60
61	EMERGENCY	.263886			61
62	OBSERVATION BEDS (NON-DISTINCT	.312416			62
	OTHER REIMBURSABLE COST CENTERS				
63.50	RHC	1.077089			63.50
63.51	RHC II	1.267653			63.51
63.52	RHC III	.713304			63.52
63.60	FQHC				63.60
65	AMBULANCE SERVICES	.438949			65
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 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02	
1	MEDICAL AND OTHER SERVICES	2736791			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	2736791			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	2764159			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1316) 1	HOSPITAL (14-1316) 1.01	HOSPITAL (14-1316) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES	21936			18
18.01	COINSURANCE	1362311			18.01
19	SUBTOTAL	1379912			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	1379912			23
24	PRIMARY PAYER PAYMENTS	111			24
25	SUBTOTAL	1379801			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	346202			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	346202			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28	SUBTOTAL	1726003			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	1726003			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1506153			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	219850			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT				51
52	THE RATE USED TO CALCULATE THE TIME VALUE				52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54	TOTAL (SUM OF LINES 51 AND 53)				54

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E, PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF (14-5470) 1	SNF (14-5470) 1.01	SNF (14-5470) 1.02	
1	MEDICAL AND OTHER SERVICES				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				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				17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF (14-5470) 1	SNF (14-5470) 1.01	SNF (14-5470) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES				18
18.01	COINSURANCE				18.01
19	SUBTOTAL				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				23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL				25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS				27
27.01	REDUCED REIMBURSABLE BAD DEBTS				27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)				27.02
28	SUBTOTAL				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				32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS				34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM				35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36
	TO BE COMPLETED BY CONTRACTOR				
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)				50
51	OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT				51
52	THE RATE USED TO CALCULATE THE TIME VALUE				52
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)				53
54	TOTAL (SUM OF LINES 51 AND 53)				54

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED WORKSHEET E-1

HOSPITAL (14-1316)

	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				666109		773529	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		325138	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	03/12/2010	36476	03/12/2010	47168	3.01
		PROGRAM TO	.02	08/20/2010	9851	08/20/2010	360318	3.02
			.03					3.03
		PROVIDER	.04					3.04
			.05					3.05
			.50	03/10/2010	4896			3.50
		PROVIDER	.51					3.51
		TO	.52				NONE	3.52
		PROGRAM	.53					3.53
			.54					3.54
	SUBTOTAL		.99		41431		407486	3.99
4	TOTAL INTERIM PAYMENTS				707540		1506153	4
	TO BE COMPLETED BY INTERMEDIARY							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
		TO	.02		NONE		NONE	5.02
		PROVIDER	.03					5.03
		PROVIDER	.50					5.50
		TO	.51		NONE		NONE	5.51
		PROGRAM	.52					5.52
	SUBTOTAL		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		319344		219850	6.01
		PROVIDER TO PROGRAM	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				1026884		1726003	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

SKILLED NURSING FACILITY I (14-5470)

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				113839			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01					3.01
	PROGRAM	.02					3.02
	TO	.03		NONE		NONE	3.03
	PROVIDER	.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER	.51					3.51
	TO	.52		NONE		NONE	3.52
	PROGRAM	.53					3.53
		.54					3.54
SUBTOTAL		.99					3.99
4 TOTAL INTERIM PAYMENTS				113839			4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02		NONE		NONE	5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51		NONE		NONE	5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01					6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				113839			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-Z316)

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				640579			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	08/20/2010	37389			3.01
	PROGRAM TO	.02					3.02
	PROVIDER	.03				NONE	3.03
		.04					3.04
		.05					3.05
		.50	03/12/2010	7392			3.50
	PROVIDER TO	.51					3.51
	PROGRAM	.52				NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		29997			3.99
4 TOTAL INTERIM PAYMENTS				670576			4
	TO BE COMPLETED BY INTERMEDIARY						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01					5.01
	TO	.02		NONE		NONE	5.02
	PROVIDER	.03					5.03
	PROVIDER	.50					5.50
	TO	.51		NONE		NONE	5.51
	PROGRAM	.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		165369			6.01
	PROVIDER TO PROGRAM	.02					6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				835945			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-Z316)	S/B SNF PART B (14-Z316)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		597558				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		258161				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		731				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		855719				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		855719				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		855719				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		19774				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		835945				15
16	OTHER ADJUSTMENTS						16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)						17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES						17.01
18	TOTAL		835945				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		670576				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		165369				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2						22

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3
PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL (14-1316)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	1168466						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	1168466						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	1180151						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 (14-1316)	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	1180151						19
20	DEDUCTIBLES	182548						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	997603						22
23	COINSURANCE							23
24	SUBTOTAL	997603						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	29281						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	29281						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							25.02
26	SUBTOTAL	1026884						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	CALCULATION ERROR ON WORKSHEET S-7							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	1026884						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	707540						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	319344						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

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

		SNF I (14-5470) (PPS) 2	
	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL/SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES		2
3	INTERNS AND RESIDENTS		3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS ONLY		4
5	COST OF TEACHING PHYSICIANS		5
6	SUBTOTAL		6
7	INPATIENT PRIMARY PAYER PAYMENTS		7
8	OUTPATIENT PRIMARY PAYER PAYMENTS		8
9	SUBTOTAL		9
	COMPUTATION OF LESSER OF COST OR CHARGES		
10	ROUTINE SERVICE CHARGES		10
11	ANCILLARY SERVICE CHARGES		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 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		17
18	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)		18
19	RATIO OF LINE 17 TO LINE 18		19
20	TOTAL CUSTOMARY CHARGES		20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		22
23	COST OF COVERED SERVICES		23
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS	159364	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	159364	30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		31
32	AMOUNT FROM LINE 30	159364	32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		33

CALCULATION OF REIMBURSEMENT SETTLEMENT — WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

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

		SNF I (14-5470) (PPS) 2	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		34
35	SUBTOTAL	159364	35
36	COINSURANCE	45525	36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E, LINE 19		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
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING ON OR AFTER 10/01/05 (SEE INSTR.)		38.03
39	UTILIZATION REVIEW		39
40	SUBTOTAL	113839	40
41	INPATIENT ROUTINE SERVICE COST		41
42	MEDICARE INPATIENT ROUTINE CHARGES		42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		43
44	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)		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 PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		49
50	CALCULATION ERROR ON WORKSHEET S-7		50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		51
52	SUBTOTAL	113839	52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	113839	55
56	SEQUESTRATION ADJUSTMENT		56
57	INTERIM PAYMENTS	113839	57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)		57.01
58	BALANCE DUE PROVIDER/PROGRAM		58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		59

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 (14-1316) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I (PPS)	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	50180						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	50180						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	50180						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	50180						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	50180						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31	50180						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 (14-1316) (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	50180						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	50180						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	CALCULATION ERROR ON WORKSHEET S-7							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL	50180						52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	50180						55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM	50180						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	-122433				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	6459266				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-4219740				6
7	INVENTORY	232022				7
8	PREPAID EXPENSES	53597				8
9	OTHER CURRENT ASSETS	209159				9
10	DUE FROM OTHER FUNDS	312115				10
11	TOTAL CURRENT ASSETS	2923986				11
	FIXED ASSETS					
12	LAND	264490				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS					13
13.01	ACCUMULATED DEPRECIATION					13.01
14	BUILDINGS	11256095				14
14.01	ACCUMULATED DEPRECIATION	-3874517				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	4243011				18
18.01	ACCUMULATED DEPRECIATION	-2874678				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	9014401				21
	OTHER ASSETS					
22	INVESTMENTS	4202749				22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	1022754				25
26	TOTAL OTHER ASSETS	5225503				26
27	TOTAL ASSETS	17163890				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1687308				28
29	SALARIES, WAGES & FEES PAYABLE	829412				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)					31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	1247940				35
36	TOTAL CURRENT LIABILITIES	3764660				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	7265000				37
38	NOTES PAYABLE					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	580932				41
42	TOTAL LONG TERM LIABILITIES	7845932				42
43	TOTAL LIABILITIES	11610592				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	5553298				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	5553298				51
52	TOTAL LIABILITIES AND FUND BALANCES	17163890				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	5501175				1
2	NET INCOME (LOSS)	52123				2
3	TOTAL	5553298				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS					10
11	SUBTOTAL	5553298				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	5553298				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	1648129		1648129	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	1101508		1101508	4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY	4004192		4004192	6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	6753829		6753829	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	6753829		6753829	16
17	ANCILLARY SERVICES	5647657	27244302	32891959	17
18	OUTPATIENT SERVICES				18
18.50	RHC		1995211	1995211	18.50
18.51	RHC II		225288	225288	18.51
18.52	RHC III		526889	526889	18.52
18.60	FQHC				18.60
19	HOME HEALTH AGENCY				19
20	AMBULANCE		1357019	1357019	20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24	PROFESSIONAL FEES	12718	163772	176490	24
25	TOTAL PATIENT REVENUES	12414204	31512481	43926685	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		19645004	26
27	ADD (SPECIFY)			27
28	BAD DEBTS	1577812		28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS		1577812	33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		21222816	40

STATEMENT OF REVENUES AND EXPENSES — WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	43926685	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	23521680	2
3	NET PATIENT REVENUES	20405005	3
4	LESS - TOTAL OPERATING EXPENSES	21222816	4
5	NET INCOME FROM SERVICE TO PATIENTS	-817811	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	1005	6
7	INCOME FROM INVESTMENTS	110256	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		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	49365	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	4854	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	15594	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TRUST INCOME		24
24.01	MISCELLANEOUS INCOME	7258	24.01
24.02	UNREALIZED GAINS		24.02
24.03	GRANTS	175834	24.03
24.04	CATERING	21426	24.04
24.05	MEDICAID ASSESSMENT REVENUE		24.05
24.06	COUNTY TERRACE	484342	24.06
25	TOTAL OTHER INCOME	869934	25
26	TOTAL	52123	26
27	LOSS ON DISPOSAL		27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	52123	31

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

	COST CENTER DESCRIPTION	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	4A	25	26	27	
	GENERAL SERVICE COST CENTERS						
1	OLD CAP REL COSTS-BLDG & FIXT						1
2	OLD CAP REL COSTS-MVBLE EQUIP						2
3	NEW CAP REL COSTS-BLDG & FIXT						3
4	NEW CAP REL COSTS-MVBLE EQUIP						4
5	EMPLOYEE BENEFITS						5
6	ADMINISTRATIVE & GENERAL						6
7	MAINTENANCE & REPAIRS						7
8	OPERATION OF PLANT						8
9	LAUNDRY & LINEN SERVICE						9
10	HOUSEKEEPING						10
11	DIETARY						11
12	CAFETERIA						12
13	MAINTENANCE OF PERSONNEL						13
14	NURSING ADMINISTRATION						14
15	CENTRAL SERVICES & SUPPLY						15
16	PHARMACY						16
17	MEDICAL RECORDS & LIBRARY						17
18	SOCIAL SERVICE						18
20	NONPHYSICIAN ANESTHETISTS						20
21	NURSING SCHOOL						21
22	I&R SERVICES-SALARY & FRINGES						22
23	I&R SERVICES-OTHER PRGM COSTS						23
24	PARAMED ED PRGM-(SPECIFY)						24
	INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS						25
34	SKILLED NURSING FACILITY						34
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM						37
40	ANESTHESIOLOGY						40
41	RADIOLOGY-DIAGNOSTIC						41
44	LABORATORY						44
46.30	BLOOD CLOTTING FACTORS ADMIN C						46.30
49	RESPIRATORY THERAPY						49
50	PHYSICAL THERAPY						50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
55	MEDICAL SUPPLIES CHARGED TO PA						55
55.30	IMPL. DEV. CHARGED TO PATIENT						55.30
56	DRUGS CHARGED TO PATIENTS						56
59.97	CARDIAC REHABILITATION						59.97
59.98	HYPERBARIC OXYGEN THERAPY						59.98
59.99	LITHOTRIPSY						59.99
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
61	EMERGENCY						61
62	OBSERVATION BEDS (NON-DISTINCT						62
63.50	RHC						63.50
63.51	RHC II						63.51
63.52	RHC III						63.52
63.60	FQHC						63.60
	OTHER REIMBURSABLE COST CENTERS						
65	AMBULANCE SERVICES						65
69.10	CMHC						69.10
69.20	OUTPATIENT PHYSICAL THERAPY						69.20
69.30	OUTPATIENT OCCUPATIONAL THERAP						69.30
69.40	OUTPATIENT SPEECH PATHOLOGY						69.40
71	HOME HEALTH AGENCY						71
	SPECIAL PURPOSE COST CENTERS						
85.01	PANCREAS ACQUISITION						85.01
85.02	INTESTINAL ACQUISITION						85.02
85.03	ISLET CELL ACQUISITION						85.03
95	SUBTOTALS						95
	NONREIMBURSABLE COST CENTERS						
96	GIFT, FLOWER, COFFEE SHOP & CA						96
99.01	ASSISTED LIVING						99.01
100	FOUNDATION						100
101	CROSS FOOT ADJUSTMENTS						101
102	NEGATIVE COST CENTER						102
103	TOTAL						103
104	TOTAL STATISTICAL BASIS						104
105	UNIT COST MULTIPLIER						105
105	UNIT COST MULTIPLIER						105

RHC I WORKSHEET M-1

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

COMPONENT NO: 14-3448

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN								1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	1094024	338758	1432782	-103279	1329503		1329503	9
10	SUBTOTAL (SUM OF LINES 1-9)	1094024	338758	1432782	-103279	1329503		1329503	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								15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)								21
22	TOTAL COSTS OF HEALTH CARE SERVICES	1094024	338758	1432782	-103279	1329503		1329503	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD								31
32	TOTAL FACILITY COSTS	1094024	338758	1432782	-103279	1329503		1329503	32

RHC I WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3448

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	2.04	16253	4200	8568		1
2	PHYSICIAN ASSISTANTS	3.24		2100	6804		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	5.28	16253		15372	16253	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	5.28	16253			16253	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	1329503	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	1329503	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	819516	15
16	TOTAL OVERHEAD	819516	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	819516	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	819516	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2149019	20

RHC I WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3448

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2149019	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	74560	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	2074459	3
4	TOTAL VISITS	16253	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	16253	6
7	ADJUSTED COST PER VISIT	127.64	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	127.64	127.64		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	908	2681		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	115897	342203		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			458100	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			34191	17
18	NET PROGRAM COST EXCLUDING VACCINES			423909	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			339127	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			35915	20
21	TOTAL REIMBURSABLE PROGRAM COST			375042	21
22	REIMBURSABLE BAD DEBTS				22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			375042	24
25	INTERIM PAYMENTS			309002	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			66040	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

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

RHC I WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3448

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	1329503	1329503	1329503	1329503	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.014600	0.014600			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	19411	19411			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	200	7105			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	19611	26516			5
6	TOTAL DIRECT COST OF THE FACILITY	1329503	1329503	1329503	1329503	6
7	TOTAL OVERHEAD	819516	819516	819516	819516	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.014751	0.019944			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	12089	16344			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	31700	42860			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	21	748			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	1509.52	57.30			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	11	337			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	16605	19310			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		74560			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		35915			16

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

RHC I COMPONENT NO: 14-3448

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				317237	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01			3.01
		PROGRAM TO	.02			3.02
		PROVIDER	.03		NONE	3.03
			.04			3.04
			.05			3.05
			.50	03/12/2010	8235	3.50
		PROVIDER TO	.51			3.51
		PROGRAM	.52			3.52
			.53			3.53
			.54			3.54
	SUBTOTAL		.99		-8235	3.99
4	TOTAL INTERIM PAYMENTS				309002	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02		NONE	5.02
		PROVIDER	.03			5.03
		PROVIDER	.50			5.50
		TO	.51		NONE	5.51
		PROGRAM	.52			5.52
	SUBTOTAL		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		66040	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				375042	7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

RHC II WORKSHEET M-1

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

COMPONENT NO: 14-3485

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN								1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	157925	69536	227461	-24470	202991		202991	9
10	SUBTOTAL (SUM OF LINES 1-9)	157925	69536	227461	-24470	202991		202991	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								15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)								21
22	TOTAL COSTS OF HEALTH CARE SERVICES	157925	69536	227461	-24470	202991		202991	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD								31
32	TOTAL FACILITY COSTS	157925	69536	227461	-24470	202991		202991	32

RHC II WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3485

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS			4200			1
2	PHYSICIAN ASSISTANTS	0.83	1768	2100	1743		2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	0.83	1768		1743	1768	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	0.83	1768			1768	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	202991	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	202991	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	82596	15
16	TOTAL OVERHEAD	82596	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	82596	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	82596	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	285587	20

RHC II WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
COMPONENT NO: 14-3485

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	285587	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	3298	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	282289	3
4	TOTAL VISITS	1768	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	1768	6
7	ADJUSTED COST PER VISIT	159.67	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	159.67	159.67		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	89	361		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	14211	57641		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			71852	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			5518	17
18	NET PROGRAM COST EXCLUDING VACCINES			66334	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			53067	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			1092	20
21	TOTAL REIMBURSABLE PROGRAM COST			54159	21
22	REIMBURSABLE BAD DEBTS			144	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			144	22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			54303	24
25	INTERIM PAYMENTS			42419	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			11884	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

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

RHC II WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST COMPONENT NO: 14-3485

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	202991	202991	202991	202991	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.004488	0.004488			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	911	911			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	47	475			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	958	1386			5
6	TOTAL DIRECT COST OF THE FACILITY	202991	202991	202991	202991	6
7	TOTAL OVERHEAD	82596	82596	82596	82596	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.004719	0.006828			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	390	564			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	1348	1950			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	5	50			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	269.60	39.00			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES		28			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		1092			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		3298			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		1092			16

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

RHC II COMPONENT NO: 14-3485

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				36791	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	03/12/2010	5628	3.01
		PROGRAM	.02			3.02
		TO	.03			3.03
		PROVIDER	.04			3.04
			.05			3.05
			.50			3.50
		PROVIDER	.51			3.51
		TO	.52		NONE	3.52
		PROGRAM	.53			3.53
			.54			3.54
	SUBTOTAL		.99		5628	3.99
4	TOTAL INTERIM PAYMENTS				42419	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02		NONE	5.02
		PROVIDER	.03			5.03
		PROVIDER	.50			5.50
		TO	.51		NONE	5.51
		PROGRAM	.52			5.52
	SUBTOTAL		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		11884	6.01
		PROVIDER TO PROGRAM	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				54303	7

NAME OF INTERMEDIARY: _____ INTERMEDIARY NUMBER: _____

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

RHC III WORKSHEET M-1

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

COMPONENT NO: 14-3496

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

		COMPEN-SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXPENSES FOR ALLOCATION 7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN								1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER								3
4	VISITING NURSE								4
5	OTHER NURSE								5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	213508	71568	285076	-20714	264362		264362	9
10	SUBTOTAL (SUM OF LINES 1-9)	213508	71568	285076	-20714	264362		264362	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								15
16	TRANSPORTATION (HEALTH CARE STAFF)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSINAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (SUM OF LINES 15-20)								21
22	TOTAL COSTS OF HEALTH CARE SERVICES	213508	71568	285076	-20714	264362		264362	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS								30
31	TOTAL FACILITY OVERHEAD								31
32	TOTAL FACILITY COSTS	213508	71568	285076	-20714	264362		264362	32

RHC III WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES COMPONENT NO: 14-3496

CHECK [XX] RHC
APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS	1.00	5396	4200	4200		1
2	PHYSICIAN ASSISTANTS			2100			2
3	NURSE PRACTITIONERS			2100			3
4	SUBTOTAL	1.00	5396		4200	5396	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
8	TOTAL FTEs AND VISITS	1.00	5396			5396	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES	264362	10
11	TOTAL NONREIMBURSABLE COSTS		11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD)	264362	12
13	RATIO OF RHC/FQHC SERVICES	1.000000	13
14	TOTAL FACILITY OVERHEAD		14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY	111470	15
16	TOTAL OVERHEAD	111470	16
17	ALLOWABLE GME OVERHEAD		17
18	SUBTRACT LINE 17 FROM LINE 16	111470	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES	111470	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	375832	20

RHC III WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES COMPONENT NO: 14-3496

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	375832	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	6134	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	369698	3
4	TOTAL VISITS	5396	4
5	PHYSICIANS VISITS UNDER AGREEMENT		5
6	TOTAL ADJUSTED VISITS	5396	6
7	ADJUSTED COST PER VISIT	68.51	7

		CALCULATION OF LIMIT(1) PRIOR TO JANUARY 1 (1)	ON OR AFTER JANUARY 1 (2)	(SEE INSTR.) (3)	
8	PER VISIT PAYMENT LIMIT				8
9	RATE FOR PROGRAM COVERED VISITS	68.51	68.51		9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	291	755		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	19936	51725		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			71661	16
16.01	PRIMARY PAYOR PAYMENTS				16.01
17	LESS: BENEFICIARY DEDUCTIBLE			12871	17
18	NET PROGRAM COST EXCLUDING VACCINES			58790	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			47032	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			2534	20
21	TOTAL REIMBURSABLE PROGRAM COST			49566	21
22	REIMBURSABLE BAD DEBTS			1142	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			1142	22.01
23	OTHER ADJUSTMENTS				23
24	NET REIMBURSABLE AMOUNT			50708	24
25	INTERIM PAYMENTS			59208	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				25.01
26	BALANCE DUE COMPONENT/PROGRAM			-8500	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2				27

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

RHC III WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT NO: 14-3496

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	264362	264362	264362	264362	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.005504	0.005504			2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	1455	1455			3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	123	1282			4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	1578	2737			5
6	TOTAL DIRECT COST OF THE FACILITY	264362	264362	264362	264362	6
7	TOTAL OVERHEAD	111470	111470	111470	111470	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.005969	0.010353			8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	665	1154			9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	2243	3891			10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	13	135			11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	172.54	28.82			12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	6	52			13
14	MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	1035	1499			14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		6134			15
16	TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		2534			16

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

RHC III COMPONENT NO: 14-3496

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				57112	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	03/12/2010	2096	3.01
		PROGRAM	.02			3.02
		TO	.03			3.03
		PROVIDER	.04			3.04
			.05			3.05
			.50			3.50
		PROVIDER	.51			3.51
		TO	.52		NONE	3.52
		PROGRAM	.53			3.53
			.54			3.54
	SUBTOTAL		.99		2096	3.99
4	TOTAL INTERIM PAYMENTS				59208	4
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
		TO	.02		NONE	5.02
		PROVIDER	.03			5.03
		PROVIDER	.50			5.50
		TO	.51		NONE	5.51
		PROGRAM	.52			5.52
	SUBTOTAL		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01			6.01
		PROVIDER TO PROGRAM	.02		-8500	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY				50708	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	55.74		5.01				60.75	25
UTILIZATION PERCENTAGES BASED ON CHARGES									
37	OPERATING ROOM	6.67	34.03					40.70	37
41	RADIOLOGY-DIAGNOSTIC	2.04	26.30					28.34	41
44	LABORATORY	6.01	31.65					37.66	44
49	RESPIRATORY THERAPY	10.46	24.01					34.47	49
50	PHYSICAL THERAPY	2.76	21.68					24.44	50
55	MEDICAL SUPPLIES CHARGED TO PAT	17.60	36.37					53.97	55
56	DRUGS CHARGED TO PATIENTS	36.15	26.08					62.23	56
60	CLINIC		82.13					82.13	60
61	EMERGENCY	0.05	20.74					20.79	61
62	OBSERVATION BEDS (NON-DISTINCT		49.05					49.05	62
101	TOTAL CHARGES	4.00	19.94					23.94	101

***** REPORT 97 ***** UTILIZATION STATISTICS ***** SNF / NF

	COST CENTERS	SNF TITLE XVIII PART A 1	SNF TITLE XVIII PART B 2	NF TITLE XIX INPATIENT 3	NF TITLE XIX OUTPATIENT 4	NF TITLE V INPATIENT 5	NF TITLE V OUTPATIENT 6	TOTAL THIRD PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON DAYS									
34	SKILLED NURSING FACILITY	1.83						1.83	34
UTILIZATION PERCENTAGES BASED ON CHARGES									
41	RADIOLOGY-DIAGNOSTIC	0.06						0.06	41
44	LABORATORY	0.35						0.35	44
49	RESPIRATORY THERAPY	0.77						0.77	49
50	PHYSICAL THERAPY	7.26						7.26	50
55	MEDICAL SUPPLIES CHARGED TO PAT	2.30						2.30	55
56	DRUGS CHARGED TO PATIENTS	8.81						8.81	56
101	TOTAL CHARGES	0.69						0.69	101

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	OLD CAP REL COSTS-BLDG & FIXT							1
2	OLD CAP REL COSTS-MVBLE EQUIP							2
3	NEW CAP REL COSTS-BLDG & FIXT	489254	2.63	-489254	-6.02			3
4	NEW CAP REL COSTS-MVBLE EQUIP	1447978	7.80	-1447978	-17.81			4
5	EMPLOYEE BENEFITS	1315899	7.08	-1315899	-16.19			5
6	ADMINISTRATIVE & GENERAL	2698664	14.53	-2698664	-33.19			6
7	MAINTENANCE & REPAIRS							7
8	OPERATION OF PLANT	691411	3.72	-691411	-8.50			8
9	LAUNDRY & LINEN SERVICE	105297	.57	-105297	-1.30			9
10	HOUSEKEEPING	301309	1.62	-301309	-3.71			10
11	DIETARY	676342	3.64	-676342	-8.32			11
12	CAFETERIA							12
13	MAINTENANCE OF PERSONNEL							13
14	NURSING ADMINISTRATION	9683	.05	-9683	-.12			14
15	CENTRAL SERVICES & SUPPLY							15
16	PHARMACY							16
17	MEDICAL RECORDS & LIBRARY	339289	1.83	-339289	-4.17			17
18	SOCIAL SERVICE	55138	.30	-55138	-.68			18
20	NONPHYSICIAN ANESTHETISTS							20
21	NURSING SCHOOL							21
22	I&R SERVICES-SALARY & FRINGES A							22
23	I&R SERVICES-OTHER PRGM COSTS A							23
24	PARAMED ED PRGM-(SPECIFY)							24
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	794645	4.28	867902	10.67	1662547	8.95	25
34	SKILLED NURSING FACILITY	1531094	8.24	2149901	26.44	3680995	19.82	34
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	1298459	6.99	567911	6.99	1866370	10.05	37
40	ANESTHESIOLOGY	23149	.12	7892	.10	31041	.17	40
41	RADIOLOGY-DIAGNOSTIC	857059	4.61	660451	8.12	1517510	8.17	41
44	LABORATORY	712296	3.83	420764	5.18	1133060	6.10	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	RESPIRATORY THERAPY	58703	.32	100819	1.24	159522	.86	49
50	PHYSICAL THERAPY	400769	2.16	204253	2.51	605022	3.26	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
55	MEDICAL SUPPLIES CHARGED TO PAT	258444	1.39	118361	1.46	376805	2.03	55
55.30	IMPL. DEV. CHARGED TO PATIENT							55.30
56	DRUGS CHARGED TO PATIENTS	606554	3.27	184042	2.26	790596	4.26	56
59.97	CARDIAC REHABILITATION							59.97
59.98	HYPERBARIC OXYGEN THERAPY							59.98
59.99	LITHOTRIPSY							59.99
60	CLINIC	324424	1.75	160135	1.97	484559	2.61	60
61	EMERGENCY	1151791	6.20	722197	8.88	1873988	10.09	61
62	OBSERVATION BEDS (NON-DISTINCT							62
63.50	RHC	1329503	7.16	819516	10.08	2149019	11.57	63.50

	COST CENTER	--- DIRECT COSTS --- AMOUNT	%	-- ALLOCATED OVERHEAD -- AMOUNT	%	--- TOTAL COSTS --- AMOUNT	%	
63.51	RHC II	202991	1.09	82596	1.02	285587	1.54	63.51
63.52	RHC III	264362	1.42	111470	1.37	375832	2.02	63.52
63.60	FQHC							63.60
	OTHER REIMBURSABLE COST CENTERS							
65	AMBULANCE SERVICES	415940	2.24	179722	2.21	595662	3.21	65
	OUTPATIENT SERVICE COST CENTERS							
69.10	CMHC							69.10
69.20	OUTPATIENT PHYSICAL THERAPY							69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	OUTPATIENT SPEECH PATHOLOGY							69.40
71	HOME HEALTH AGENCY							71
	SPECIAL PURPOSE COST CENTERS							
85.01	PANCREAS ACQUISITION							85.01
85.02	INTESTINAL ACQUISITION							85.02
85.03	ISLET CELL ACQUISITION							85.03
	NONREIMBURSABLE COST CENTERS							
96	GIFT, FLOWER, COFFEE SHOP & CAN			50243	.62	50243	.27	96
99.01	ASSISTED LIVING	213953	1.15	722089	8.88	936042	5.04	99.01
100	FOUNDATION							100
101	CROSS FOOT ADJUSTMENTS							101
102	NEGATIVE COST CENTER							102
103	TOTAL	18574400	100.00	0	.00	18574400	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)	2604566
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)	8256723
3.	RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.315