MEDICARE COST ANALYSIS

MARSHALL BROWNING HOSPITAL

DUQUOIN, ILLINOIS

YEAR ENDED JUNE 30, 2008

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

WORKSHEET S
PARTS I & II

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

PART I - CERTIFICATION

CHECK APPLICABLE BOX	XX ELECTRONICALLY FILED COST REPORT	DATE: _11/10/2008
	__ MANUALLY SUBMITTED COST REPORT	TIME: _16:36____

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 MARSHALL BROWNING HOSPITAL (14 1331 (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2007 AND ENDING 06/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/10/2008 16:36
4O1jDGuzK:Jkvkcd2dtVJhOy7sHGG0
wJWtP0mH6VfAxIBxrXv2bFwhFEE1Nu
qxU40pa8hA0PIz0I

PI Encryption: 11/10/2008 16:36
YvhvlPgBhGNXceX9pyQVQ6aF.3PNq0
PlV6L0NetxOmrIxkS3LchhgN1Z1Q9l
a77Q6m2WBH0uWVHA

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

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII PART A	TITLE XVIII PART B	TITLE XIX	
		1	2	3	4	
1	HOSPITAL		177310	-107361		1
2	SUBPROVIDER I					2
3	SWING BED - SNF		-14163			3
4	SWING BED - NF					4
5	SKILLED NURSING FACILITY					5
6	NURSING FACILITY					6
7	HOME HEALTH AGENCY					7
8	OUTPATIENT REHABILITATION PROVIDER					8
9	HEALTH CLINIC					9
100	TOTAL		163147	-107361		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: 900 NORTH WASHINGTON STREET P.O.BOX: 1
1.01 CITY: DUQUOIN STATE: IL ZIP CODE: 62832 COUNTY: PERRY 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V 4	XVIII 5	XIX 6	
2	HOSPITAL	MARSHALL BROWNING HOSPITAL	14-1331	01/01/2004	N	O	P	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	MARSHALL BROWNING SWING BED	14-Z331	01/01/2004	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA							9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC							14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 07/01/2007 TO: 06/30/2008 17

		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?				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	99914	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.	2			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.	NO			21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW	NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COl. 3.				23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.				23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.				23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.				24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER: ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.				24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)				25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)				25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	01/01/2004	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) If YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02

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

28.03	STAFFING	0.00	N	28.03
28.04	RECRUITMENT	0.00	N	28.04
28.05	RETENTION OF EMPLOYEES	0.00	N	28.05
28.06	TRAINING	0.00	N	28.06
28.07	OTHER (SPECIFY)			28.07

29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO	29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES	30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO	30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO	30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO	30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO	30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	YES	31

MISCELLANEOUS COST REPORTING INFORMATION

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

		V	XVIII	XIX	
	PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES	38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO	38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO	38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO	38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO	38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO	40
40.01	NAME: FI/CONTRACTOR'S NAME: FI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET: P.O.BOX:		40.02
40.03	CITY: STATE: ZIP CODE:		40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES	41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES	42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO	43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO	44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15 II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO	45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.		46

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

		PART A 1	PART B 2	OUTPATIENT ASC 3	OUTPATIENT RADIOLOGY 4	OUTPATIENT DIAGNOSTIC 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: PREMIUMS: 169092 PAID LOSSES: AND/OR SELF INSURANCE:		54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	NO	54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO	55

		DATE 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
(CONTINUED)

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

MULTICAMPUS

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

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

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH PATIENT HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	LTCH NONCOVERED DAYS 4.01	TITLE XIX 5	OBS. BEDS ADMITTED 5.01	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS	25	9150	62544.00		1974		204		1
2	HMO									2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					722				3
4	HOSPITAL ADULTS & PEDS - SWING BED NF									4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS	25	9150	62544.00		2696		204		5
6	INTENSIVE CARE UNIT									6
7	CORONARY CARE UNIT									7
8	BURN INTENSIVE CARE UNIT									8
9	SURGICAL INTENSIVE CARE UNIT									9
10	OTHER SPECIAL CARE (SPECIFY									10
11	NURSERY									11
12	TOTAL HOSPITAL	25	9150	62544.00		2696		204		12
13	RPCH VISITS									13
14	SUBPROVIDER I									14
15	SKILLED NURSING FACILITY									15
16	NURSING FACILITY									16
17	OTHER LONG TERM CARE									17
18	HOME HEALTH AGENCY									18
20	ASC (DISTINCT PART)									20
21	HOSPICE (DISTINCT PART)									21
23	O/P REHAB PROVIDER									23
24	RHC I									24
25	TOTAL	25								25
26	OBSERVATION BED DAYS							12	2	26
27	AMBULANCE TRIPS									27
28	EMPLOYEE DISCOUNT DAYS									28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS: OBS. BEDS NOT ADMITTED 5.02	TOTAL ALL PATIENTS 6	OBS. BEDS ADMITTED 6.01	OBS. BEDS NOT ADMITTED 6.02	INTERNS & RES FTES: TOTAL 7	LESS I&R REPL NON-PHYS ANES 8	NET 9	FULL TIME EQUIV: EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	
1	HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS		2606								1
2	HMO XIX										2
3	HOSPITAL ADULTS & PEDS SWING BED SNF		722								3
4	HOSPITAL ADULTS & PEDS SWING BED NF		58								4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS		3386								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		3386						167.42		12
13	RPCH VISITS										13
14	SUBPROVIDER I										14
15	SKILLED NURSING FACILITY										15
16	NURSING FACILITY										16
17	OTHER LONG TERM CARE										17
18	HOME HEALTH AGENCY										18
20	ASC (DISTINCT PART)										20
21	HOSPICE (DISTINCT PART)										21
23	O/P REHAB PROVIDER										23
24	RHC I										24
25	TOTAL								167.42		25
26	OBSERVATION BED DAYS	10	195	31	164						26
27	AMBULANCE TRIPS										27
28	EMPLOYEE DISCOUNT DAYS										28

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I
(CONTINUED)

	COMPONENT	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		474	73	754	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		474	73	754	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER	SALARIES 1	OTHER 2	TOTAL 3	RECLASSI-FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST-MENTS 6	NET EXP FOR ALLOCATION 7	
		GENERAL SERVICE COST CENTERS								
3	0300	NEW CAP REL COSTS BLDG & FIXT		341241	341241	216978	558219	-7174	551045	3
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		412393	412393	71834	484227	-2285	481942	4
5	0500	EMPLOYEE BENEFITS		1785971	1785971		1785971		1785971	5
6	0600	ADMINISTRATIVE & GENERAL	812180	2267254	3079434		3079434	-1351271	1728163	6
7	0700	MAINTENANCE & REPAIRS	153670	143207	296877		296877	-141	296736	7
8	0800	OPERATION OF PLANT		323687	323687		323687		323687	8
9	0900	LAUNDRY & LINEN SERVICE	26670	44040	70710		70710		70710	9
10	1000	HOUSEKEEPING	253924	30636	284560		284560	-86	284474	10
11	1100	DIETARY	239969	159129	399098	-267395	131703	-922	130781	11
12	1200	CAFETERIA				267395	267395	-53444	213951	12
14	1400	NURSING ADMINISTRATION	456935	14089	471024		471024	-778	470246	14
16	1600	PHARMACY		763271	763271		763271	-40668	722603	16
17	1700	MEDICAL RECORDS & LIBRARY	186138	16607	202745		202745	815	203560	17
18	1800	SOCIAL SERVICE	44893	180	45073		45073	-289	44784	18
		INPATIENT ROUTINE SERV COST CENTERS								
25	2500	ADULTS & PEDIATRICS	865323	38323	903646		903646	19221	922867	25
		ANCILLARY SERVICE COST CENTERS								
37	3700	OPERATING ROOM	250459	32678	283137		283137	6569	289706	37
40	4000	ANESTHESIOLOGY	166977	20300	187277		187277		187277	40
41	4100	RADIOLOGY DIAGNOSTIC	393499	415628	809127		809127	-1162	807965	41
44	4400	LABORATORY	434447	181300	615747		615747	7885	623632	44
49	4900	RESPIRATORY THERAPY	228465	60017	288482		288482	1616	290098	49
50	5000	PHYSICAL THERAPY	450198	59340	509538		509538	-654	508884	50
51	5100	OCCUPATIONAL THERAPY								51
52	5200	SPEECH PATHOLOGY								52
53	5300	ELECTROCARDIOLOGY	17325	27205	44530		44530	-26140	18390	53
55	5500	MEDICAL SUPPLIES CHARGED TO PAT		665812	665812		665812		665812	55
56	5600	DRUGS CHARGED TO PATIENTS								56
56.01	5601	CARDIAC REHABILITATION	23845	6000	29845		29845	-6000	23845	56.01
		OUTPATIENT SERVICE COST CENTERS								
60	6000	CLINIC								60
61	6100	EMERGENCY	378003	899384	1277387		1277387	-475715	801672	61
62	6200	OBSERVATION BEDS (NON DISTINCT								62
		OTHER REIMBURSABLE COST CENTERS								
71	7100	HOME HEALTH AGENCY								71
		SPECIAL PURPOSE COST CENTERS								
88	8800	INTEREST EXPENSE		272656	272656	-220738	51918	-51918		88
90	9000	OTHER CAPITAL RELATED COSTS		68074	68074	-68074				90
95		SUBTOTALS	5382920	9048422	14431342		14431342	-1982541	12448801	95
		NONREIMBURSABLE COST CENTERS								
96	9600	GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800	PHYSICIANS' PRIVATE OFFICES	722651	275051	997702		997702	-754	996948	98
98.02	9802	INDEPENDENT LIVING	67562	107765	175327		175327		175327	98.02
98.03	9803	MEALS ON WHEELS								98.03
101		TOTAL	6173133	9431238	15604371		15604371	-1983295	13621076	101

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS	A	CAFETERIA	12	160779	106616	1
2	TO RECLASS INTEREST EXP	C	NEW CAP REL COSTS-MVBLE EQUIP	4		55917	2
3		C	NEW CAP REL COSTS-BLDG & FIXT	3		164821	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				160779	327354	36

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE LINE # 7	SALARY 8	OTHER 9	WKST A-7 REF. 10
1	TO RECLASS CAFETERIA COSTS	A	DIETARY	11	160779	106616	1
2	TO RECLASS INTEREST EXP	C	INTEREST EXPENSE	88		220738	11 2
3		C					11 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				160779	327354	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	3116					3116		1
2	LAND IMPROVEMENTS	476896	255772		255772	11674	720994		2
3	BUILDINGS AND FIXTURES	5855846	1698290		1698290		7554136		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	2684985	3315579		3315579		6000564		5
6	MOVABLE EQUIPMENT	4160826	1036781		1036781	840897	4356710		6
7	SUBTOTAL	13181669	6306422		6306422	852571	18635520		7
8	RECONCILING ITEMS								8
9	TOTAL	13181669	6306422		6306422	852571	18635520		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS III & IV

	DESCRIPTION	COMPUTATION OF RATIOS: GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL: INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL	
		1	2	3	4	5	6	7	8	
1	OLD CAP REL COSTS-BLDG & FIXT				.000000					1
2	OLD CAP REL COSTS-MVBLE EQUIP				.000000					2
3	NEW CAP REL COSTS BLDG & FIXT	14275694		14275694	.766176			52157	52157	3
4	NEW CAP REL COSTS MVBLE EQUIP	4356710		4356710	.233824			15917	15917	4
5	TOTAL	18632404		18632404	1.000000			68074	68074	5

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: 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	341241		157647			52157	551045	3
4	NEW CAP REL COSTS-MVBLE EQUIP	412393		53632			15917	481942	4
5	TOTAL	753634		211279			68074	1032987	5

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL: 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	341241						341241	3
4	NEW CAP REL COSTS-MVBLE EQUIP	412393						412393	4
5	TOTAL	753634						753634	5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
1	INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1		1
2	INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME NEW BLDGS & FIXTURES	B	-6854	NEW CAP REL COSTS-BLDG & FIXT	3	11	3
4	INVESTMENT INCOME-NEW MOVABLE EQUIPMENT	B	-2285	NEW CAP REL COSTS-MVBLE EQUIP	4	11	4
5	INVESTMENT INCOME-OTHER						5
6	TRADE, QUANTITY, AND TIME DISCOUNTS						6
7	REFUNDS AND REBATES OF EXPENSES						7
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS						8
9	TELEPHONE SERVICES (PAY STATIONS EXCL)						9
10	TELEVISION AND RADIO SERVICE						10
11	PARKING LOT						11
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-505260				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	-53444	CAFETERIA	12		16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						18
19	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-53663	PHARMACY	16		19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-1226	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	MISCELLABEOUS INCOME	B	-43278	ADMINISTRATIVE & GENERAL	6		37
38	BAD DEBTS	A	-1232222	ADMINISTRATIVE & GENERAL	6		38
39	AHA DUES USED FOR LOBBYING	A	-6549	ADMINISTRATIVE & GENERAL	6		39
40	IHA DUES USED FOR LOBBYING	A	1900	ADMINISTRATIVE & GENERAL	6		40
41	MARKETING	A	-70580	ADMINISTRATIVE & GENERAL	6		41
42	EMPLOYEE GIFTS	A	-6560	ADMINISTRATIVE & GENERAL	6		42
43							43
44	DEPRECIATION	A	-320	NEW CAP REL COSTS-BLDG & FIXT	3	11	44
45	DEPRECIATION	A	9818	ADMINISTRATIVE & GENERAL	6		45
46	DEPRECIATION	A	-141	MAINTENANCE & REPAIRS	7		46
47	DEPRECIATION	A	-86	HOUSEKEEPING	10		47
48	DEPRECIATION	A	-922	DIETARY	11		48
49	DEPRECIATION	A	-778	NURSING ADMINISTRATION	14		49
49.01	DEPRECIATION	A	12995	PHARMACY	16		49.01
49.02	DEPRECIATION	A	2041	MEDICAL RECORDS & LIBRARY	17		49.02
49.03	DEPRECIATION	A	-289	SOCIAL SERVICE	18		49.03
49.04	DEPRECIATION	A	19221	ADULTS & PEDIATRICS	25		49.04
49.05	DEPRECIATION	A	6569	OPERATING ROOM	37		49.05
49.06	DEPRECIATION	A	-1162	RADIOLOGY-DIAGNOSTIC	41		49.06
49.07	DEPRECIATION	A	7885	LABORATORY	44		49.07
49.08	DEPRECIATION	A	1616	RESPIRATORY THERAPY	49		49.08
49.09	DEPRECIATION	A	-654	PHYSICAL THERAPY	50		49.09
49.10	DEPRECIATION	A	-754	PHYSICIANS' PRIVATE OFFICES	98		49.10
49.11	DEPRECIATION	A	-2595	EMERGENCY	61		49.11
49.14	UNALLOWABLE INTEREST	A	51918	INTEREST EXPENSE	88		49.14
50	TOTAL		-1983295				50

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2		TOTAL REMUNERATION INCL FRINGES 3	PROFESSIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	AGGREGATE							
2	49	RESPIRATORY THERAPY	AGGREGATE							
3	53	ELECTROCARDIOLOGY	AGGREGATE	26140	26140					
4	56.01	CARDIAC REHABILITATION	AGGREGATE	6000	6000					
5	60	CLINIC	AGGREGATE							
6	61	EMERGENCY	AGGREGATE	849408	473120	376288				
101		TOTAL		881548	505260	376288				

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUST-MENT 18
1	44	LABORATORY	AGGREGATE							26140
2	49	RESPIRATORY THERAPY	AGGREGATE							6000
3	53	ELECTROCARDIOLOGY	AGGREGATE							
4	56.01	CARDIAC REHABILITATION	AGGREGATE							473120
5	60	CLINIC	AGGREGATE							505260
6	61	EMERGENCY	AGGREGATE							
101		TOTAL								

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

WORKSHEET A-8-4
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	26	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	390	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	45	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE	101	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	4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		86.25	247.25			9
10	AHSEA		65.92	65.92			10
11	STANDARD TRAVEL ALLOWANCE	32.96	32.96	32.96			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	5686	15
16	ASSISTANTS	16299	16
17	SUBTOTAL ALLOWANCE AMOUNT	21985	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	21985	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	65.92	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	25709	22
23	TOTAL SALARY EQUIVALENCY	25709	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	1483	24
25	ASSISTANTS	3329	25
26	SUBTOTAL	4812	26
27	STANDARD TRAVEL EXPENSE	708	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	5520	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	5520	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	25709	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	5520	58
59	TRAVEL ALLOWANCE AND EXPENSE OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	31229	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	14634	64
65	EXCESS OVER LIMITATION		65

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

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	14634	66
67	TOTAL COST	14634	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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

WORKSHEET A-8-4
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	56	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	840	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	118	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	4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		428.00				9
10	AHSEA		64.53				10
11	STANDARD TRAVEL ALLOWANCE	32.27	32.27				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	27619	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	27619	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	27619	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	64.53	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	54205	22
23	TOTAL SALARY EQUIVALENCY	54205	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	3808	24
25	ASSISTANTS		25
26	SUBTOTAL	3808	26
27	STANDARD TRAVEL EXPENSE	572	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	4380	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	4380	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	54205	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	4380	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	58585	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	21375	64
65	EXCESS OVER LIMITATION		65

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

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	21375	66
67	TOTAL COST	21375	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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

WORKSHEET A-8-4
PARTS I & II

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

PART I GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)	2	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	30	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE	3	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	4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE		8

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5	
9	TOTAL HOURS WORKED		3.25				9
10	AHSEA		66.99				10
11	STANDARD TRAVEL ALLOWANCE	33.50	33.50				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	218	15
16	ASSISTANTS		16
17	SUBTOTAL ALLOWANCE AMOUNT	218	17
18	AIDES		18
19	TRAINEES		19
20	TOTAL ALLOWANCE AMOUNT	218	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES	67.08	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES	2012	22
23	TOTAL SALARY EQUIVALENCY	2012	23

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

WORKSHEET A-8-4
PARTS III & IV

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

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

	STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS	101	24
25	ASSISTANTS		25
26	SUBTOTAL	101	26
27	STANDARD TRAVEL EXPENSE	15	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	116	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	116	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT	2012	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	116	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES		59
60	OVERTIME ALLOWANCE		60
61	EQUIPMENT COST		61
62	SUPPLIES		62
63	TOTAL ALLOWANCE	2128	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	179	64
65	EXCESS OVER LIMITATION		65

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

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

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

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

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	179	66
67	TOTAL COST	179	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	MAIN-TENANCE & REPAIRS 7	OPERATION OF PLANT 8	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT	551045	551045							3
4	NEW CAP REL COSTS-MVBLE EQUIP	481942		481942						4
5	EMPLOYEE BENEFITS	1785971			1785971					5
6	ADMINISTRATIVE & GENERAL	1728163	109299	109508	234975	2181945	2181945			6
7	MAINTENANCE & REPAIRS	296736		1832	44459	343027	65430	408457		7
8	OPERATION OF PLANT	323687				323687	61741		385428	8
9	LAUNDRY & LINEN SERVICE	70710	12189		7716	90615	17284	1606	14684	9
10	HOUSEKEEPING	284474	3017	515	73464	361470	68948	4818	3635	10
11	DIETARY	130781	23759	453	22911	177904	33934	15525	28622	11
12	CAFETERIA	213951	5037	920	46516	266424	50819	31584	6068	12
14	NURSING ADMINISTRATION	470246	3152	831	132198	606427	115672		3797	14
16	PHARMACY	722603	8378	743		731724	139572	6424	10092	16
17	MEDICAL RECORDS & LIBRARY	203560	8391	6214	53852	272017	51886	1071	10109	17
18	SOCIAL SERVICE	44784	1616		12988	59388	11328		1947	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	922867	77203	19407	250345	1269822	242210	168628	93007	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	289706	30931	7212	72461	400310	76357	22484	37263	37
40	ANESTHESIOLOGY	187277		7523	48309	243109	46372			40
41	RADIOLOGY-DIAGNOSTIC	807965	26035	276098	113845	1223943	233460	16595	31364	41
44	LABORATORY	623632	11731	14548	125692	775603	147942	26231	14133	44
49	RESPIRATORY THERAPY	290098	10357	12356	66098	378909	72275	9101	12478	49
50	PHYSICAL THERAPY	508884	23301	14004	130249	676438	129026	33726	28071	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	18390	1266		5012	24668	4705		1525	53
55	MEDICAL SUPPLIES CHARGED TO PAT	665812				665812	127000			55
56	DRUGS CHARGED TO PATIENTS									56
56.01	CARDIAC REHABILITATION	23845	242		6899	30986	5910		292	56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	801672	16129	6561	109362	933724	178102	39079	19430	61
62	OBSERVATION BEDS (NON-DISTINCT									62
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	12448801	372033	478725	1557351	12037952	1879973	376872	316517	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		5091			5091	971		6133	96
98	PHYSICIANS' PRIVATE OFFICES	996948	52110	1210	209073	1259341	240212	16060	62778	98
98.02	INDEPENDENT LIVING	175327	121811	2007	19547	318692	60789	15525		98.02
98.03	MEALS ON WHEELS									98.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	13621076	551045	481942	1785971	13621076	2181945	408457	385428	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS-TRATION 14	PHARMACY 16	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE	124189								9
10	HOUSEKEEPING		438871							10
11	DIETARY	2398	20417	278800						11
12	CAFETERIA	4825	41356		401076					12
14	NURSING ADMINISTRATION				30772	756668				14
16	PHARMACY		7709				895521			16
17	MEDICAL RECORDS & LIBRARY		625		26277			361985		17
18	SOCIAL SERVICE				3458				76121	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	57372	160632	263116	94736	383928		134949	76121	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	9211	28959		21091	84375		37747		37
40	ANESTHESIOLOGY				3458					40
41	RADIOLOGY-DIAGNOSTIC	6345	48752		33884			68581		41
44	LABORATORY	2456	24168		42528			30419		44
49	RESPIRATORY THERAPY	7486	6875		22820			13550		49
50	PHYSICAL THERAPY	12925	20313		32155			7605		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY									53
55	MEDICAL SUPPLIES CHARGED TO PAT									55
56	DRUGS CHARGED TO PATIENTS						895521			56
56.01	CARDIAC REHABILITATION									56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	15469	48231		32847	132396		36503		61
62	OBSERVATION BEDS (NON-DISTINCT									62
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	118487	408037	263116	344026	600699	895521	329354	76121	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN									96
98	PHYSICIANS' PRIVATE OFFICES	5702	28959		48060	155969		32631		98
98.02	INDEPENDENT LIVING		1875		8990					98.02
98.03	MEALS ON WHEELS			15684						98.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	124189	438871	278800	401076	756668	895521	361985	76121	103

COST ALLOCATION GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		25	26	27	
	GENERAL SERVICE COST CENTERS				
3	NEW CAP REL COSTS-BLDG & FIXT				3
4	NEW CAP REL COSTS-MVBLE EQUIP				4
5	EMPLOYEE BENEFITS				5
6	ADMINISTRATIVE & GENERAL				6
7	MAINTENANCE & REPAIRS				7
8	OPERATION OF PLANT				8
9	LAUNDRY & LINEN SERVICE				9
10	HOUSEKEEPING				10
11	DIETARY				11
12	CAFETERIA				12
14	NURSING ADMINISTRATION				14
16	PHARMACY				16
17	MEDICAL RECORDS & LIBRARY				17
18	SOCIAL SERVICE				18
	INPATIENT ROUTINE SERV COST CENTERS				
25	ADULTS & PEDIATRICS	2944521		2944521	25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	717797		717797	37
40	ANESTHESIOLOGY	292939		292939	40
41	RADIOLOGY-DIAGNOSTIC	1662924		1662924	41
44	LABORATORY	1063480		1063480	44
49	RESPIRATORY THERAPY	523494		523494	49
50	PHYSICAL THERAPY	940259		940259	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	30898		30898	53
55	MEDICAL SUPPLIES CHARGED TO PAT	792812		792812	55
56	DRUGS CHARGED TO PATIENTS	895521		895521	56
56.01	CARDIAC REHABILITATION	37188		37188	56.01
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC				60
61	EMERGENCY	1435781		1435781	61
62	OBSERVATION BEDS (NON-DISTINCT				62
	OTHER REIMBURSABLE COST CENTERS				
71	HOME HEALTH AGENCY				71
	SPECIAL PURPOSE COST CENTERS				
95	SUBTOTALS	11337614		11337614	95
	NONREIMBURSABLE COST CENTERS				
96	GIFT, FLOWER, COFFEE SHOP & CAN	12195		12195	96
98	PHYSICIANS' PRIVATE OFFICES	1849712		1849712	98
98.02	INDEPENDENT LIVING	405871		405871	98.02
98.03	MEALS ON WHEELS	15684		15684	98.03
101	CROSS FOOT ADJUSTMENTS				101
102	NEGATIVE COST CENTER				102
103	TOTAL	13621076		13621076	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	MAIN-TENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL		109299	109508	218807	218807				6
7	MAINTENANCE & REPAIRS			1832	1832	6561	8393			7
8	OPERATION OF PLANT					6191		6191		8
9	LAUNDRY & LINEN SERVICE		12189		12189	1733	33	236	14191	9
10	HOUSEKEEPING		3017	515	3532	6914	99	58		10
11	DIETARY		23759	453	24212	3403	319	460	274	11
12	CAFETERIA		5037	920	5957	5096	649	97	551	12
14	NURSING ADMINISTRATION		3152	831	3983	11600		61		14
16	PHARMACY		8378	743	9121	13996	132	162		16
17	MEDICAL RECORDS & LIBRARY		8391	6214	14605	5203	22	162		17
18	SOCIAL SERVICE		1616		1616	1136		31		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS		77203	19407	96610	24289	3465	1495	6555	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM		30931	7212	38143	7657	462	599	1053	37
40	ANESTHESIOLOGY			7523	7523	4650				40
41	RADIOLOGY-DIAGNOSTIC		26035	276098	302133	23412	341	504	725	41
44	LABORATORY		11731	14548	26279	14836	539	227	281	44
49	RESPIRATORY THERAPY		10357	12356	22713	7248	187	200	855	49
50	PHYSICAL THERAPY		23301	14004	37305	12939	693	451	1477	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY		1266		1266	472		24		53
55	MEDICAL SUPPLIES CHARGED TO PAT					12736				55
56	DRUGS CHARGED TO PATIENTS									56
56.01	CARDIAC REHABILITATION		242		242	593		5		56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY		16129	6561	22690	17860	803	312	1768	61
62	OBSERVATION BEDS (NON-DISTINCT									62
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS		372033	478725	850758	188525	7744	5084	13539	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN		5091		5091	97		99		96
98	PHYSICIANS' PRIVATE OFFICES		52110	1210	53320	24089	330	1008	652	98
98.02	INDEPENDENT LIVING		121811	2007	123818	6096	319			98.02
98.03	MEALS ON WHEELS									98.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		551045	481942	1032987	218807	8393	6191	14191	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	
		10	11	12	14	16	17	18	25	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE									9
10	HOUSEKEEPING	10603								10
11	DIETARY	493	29161							11
12	CAFETERIA	999		13349						12
14	NURSING ADMINISTRATION			1024	16668					14
16	PHARMACY	186				23597				16
17	MEDICAL RECORDS & LIBRARY	15		875			20882			17
18	SOCIAL SERVICE			115				2898		18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	3881	27520	3153	8457		7784	2898	186107	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	700		702	1859		2178		53353	37
40	ANESTHESIOLOGY			115					12288	40
41	RADIOLOGY-DIAGNOSTIC	1178		1128			3956		333377	41
44	LABORATORY	584		1415			1755		45916	44
49	RESPIRATORY THERAPY	166		760			782		32911	49
50	PHYSICAL THERAPY	491		1070			439		54865	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY								1762	53
55	MEDICAL SUPPLIES CHARGED TO PAT								12736	55
56	DRUGS CHARGED TO PATIENTS					23597			23597	56
56.01	CARDIAC REHABILITATION								840	56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	1165		1093	2916		2106		50713	61
62	OBSERVATION BEDS (NON-DISTINCT									62
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	9858	27520	11450	13232	23597	19000	2898	808465	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & CAN								5287	96
98	PHYSICIANS' PRIVATE OFFICES	700		1600	3436		1882		87017	98
98.02	INDEPENDENT LIVING	45		299					130577	98.02
98.03	MEALS ON WHEELS		1641						1641	98.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	10603	29161	13349	16668	23597	20882	2898	1032987	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
PART III

	COST CENTER DESCRIPTION	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
	GENERAL SERVICE COST CENTERS			
3	NEW CAP REL COSTS BLDG & FIXT			3
4	NEW CAP REL COSTS-MVBLE EQUIP			4
5	EMPLOYEE BENEFITS			5
6	ADMINISTRATIVE & GENERAL			6
7	MAINTENANCE & REPAIRS			7
8	OPERATION OF PLANT			8
9	LAUNDRY & LINEN SERVICE			9
10	HOUSEKEEPING			10
11	DIETARY			11
12	CAFETERIA			12
14	NURSING ADMINISTRATION			14
16	PHARMACY			16
17	MEDICAL RECORDS & LIBRARY			17
18	SOCIAL SERVICE			18
	INPATIENT ROUTINE SERV COST CENTERS			
25	ADULTS & PEDIATRICS		186107	25
	ANCILLARY SERVICE COST CENTERS			
37	OPERATING ROOM		53353	37
40	ANESTHESIOLOGY		12288	40
41	RADIOLOGY DIAGNOSTIC		333377	41
44	LABORATORY		45916	44
49	RESPIRATORY THERAPY		32911	49
50	PHYSICAL THERAPY		54865	50
51	OCCUPATIONAL THERAPY			51
52	SPEECH PATHOLOGY			52
53	ELECTROCARDIOLOGY		1762	53
55	MEDICAL SUPPLIES CHARGED TO PAT		12736	55
56	DRUGS CHARGED TO PATIENTS		23597	56
56.01	CARDIAC REHABILITATION		840	56.01
	OUTPATIENT SERVICE COST CENTERS			
60	CLINIC			60
61	EMERGENCY		50713	61
62	OBSERVATION BEDS (NON-DISTINCT			62
	OTHER REIMBURSABLE COST CENTERS			
71	HOME HEALTH AGENCY			71
	SPECIAL PURPOSE COST CENTERS			
95	SUBTOTALS		808465	95
	NONREIMBURSABLE COST CENTERS			
96	GIFT, FLOWER, COFFEE SHOP & CAN		5287	96
98	PHYSICIANS' PRIVATE OFFICES		87017	98
98.02	INDEPENDENT LIVING		130577	98.02
98.03	MEALS ON WHEELS		1641	98.03
101	CROSS FOOT ADJUSTMENTS			101
102	NEGATIVE COST CENTER			102
103	TOTAL		1032987	103

COST ALLOCATION STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET 3	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE 4	EMPLOYEE BENEFITS GROSS SALARIES 5	RECON-CILIATION 6A	ADMINIS-TRATIVE & GENERAL ACCUM COST 6	MAIN-TENANCE & REPAIRS TIME SPENT 7	OPERATION OF PLANT SQUARE FEET 8	
	GENERAL SERVICE COST CENTERS								
3	NEW CAP REL COSTS-BLDG & FIXT	81826							3
4	NEW CAP REL COSTS-MVBLE EQUIP		412393						4
5	EMPLOYEE BENEFITS			6173133					5
6	ADMINISTRATIVE & GENERAL	16230	93705	812180	-2181945	11439131			6
7	MAINTENANCE & REPAIRS		1568	153670		343027	763		7
8	OPERATION OF PLANT					323687		47508	8
9	LAUNDRY & LINEN SERVICE	1810		26670		90615	3	1810	9
10	HOUSEKEEPING	448	441	253924		361470	9	448	10
11	DIETARY	3528	388	79190		177904	29	3528	11
12	CAFETERIA	748	787	160779		266424	59	748	12
14	NURSING ADMINISTRATION	468	711	456935		606427		468	14
16	PHARMACY	1244	636			731724	12	1244	16
17	MEDICAL RECORDS & LIBRARY	1246	5317	186138		272017	2	1246	17
18	SOCIAL SERVICE	240		44893		59388		240	18
	INPATIENT ROUTINE SERV COST CENTERS								
25	ADULTS & PEDIATRICS	11464	16606	865323		1269822	315	11464	25
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	4593	6171	250459		400310	42	4593	37
40	ANESTHESIOLOGY		6437	166977		243109			40
41	RADIOLOGY-DIAGNOSTIC	3866	236255	393499		1223943	31	3866	41
44	LABORATORY	1742	12449	434447		775603	49	1742	44
49	RESPIRATORY THERAPY	1538	10573	228465		378909	17	1538	49
50	PHYSICAL THERAPY	3460	11983	450198		676438	63	3460	50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	188		17325		24668		188	53
55	MEDICAL SUPPLIES CHARGED TO P					665812			55
56	DRUGS CHARGED TO PATIENTS								56
56.01	CARDIAC REHABILITATION	36		23845		30986		36	56.01
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
61	EMERGENCY	2395	5614	378003		933724	73	2395	61
62	OBSERVATION BEDS (NON-DISTINC								62
	OTHER REIMBURSABLE COST CENTERS								
71	HOME HEALTH AGENCY								71
	SPECIAL PURPOSE COST CENTERS								
95	SUBTOTALS	55244	409641	5382920	-2181945	9856007	704	39014	95
	NONREIMBURSABLE COST CENTERS								
96	GIFT, FLOWER, COFFEE SHOP & C	756				5091		756	96
98	PHYSICIANS' PRIVATE OFFICES	7738	1035	722651		1259341	30	7738	98
98.02	INDEPENDENT LIVING	18088	1717	67562		318692	29		98.02
98.03	MEALS ON WHEELS								98.03
101	CROSS FOOT ADJUSTMENTS								101
102	NEGATIVE COST CENTER								102
103	COST TO BE ALLOC PER B PT I	551045	481942	1785971		2181945	408457	385428	103
104	UNIT COST MULT WS B PT I		1.168647				535.330275		104
104	UNIT COST MULT-WS B PT I	6.734351		.289314		.190744		8.112907	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					218807	8393	6191	107
108	UNIT COST MULT-WS B PT III						11.000000		108
108	UNIT COST MULT-WS B PT III					.019128		.130315	108

COST ALLOCATION STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE-KEEPING TIME SPENT 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	NURSING ADMINIS-TRATION HOURS SUPERVISED 14	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	
	GENERAL SERVICE COST CENTERS									
3	NEW CAP REL COSTS-BLDG & FIXT									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
9	LAUNDRY & LINEN SERVICE	4247								9
10	HOUSEKEEPING		4213							10
11	DIETARY	82	196	15607						11
12	CAFETERIA	165	397		1160					12
14	NURSING ADMINISTRATION				89	112475				14
16	PHARMACY		74				100			16
17	MEDICAL RECORDS & LIBRARY		6		76			2618		17
18	SOCIAL SERVICE				10				480	18
	INPATIENT ROUTINE SERV COST CENTERS									
25	ADULTS & PEDIATRICS	1962	1542	14729	274	57069		976	480	25
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	315	278		61	12542		273		37
40	ANESTHESIOLOGY				10					40
41	RADIOLOGY-DIAGNOSTIC	217	468		98			496		41
44	LABORATORY	84	232		123			220		44
49	RESPIRATORY THERAPY	256	66		66			98		49
50	PHYSICAL THERAPY	442	195		93			55		50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY									53
55	MEDICAL SUPPLIES CHARGED TO P									55
56	DRUGS CHARGED TO PATIENTS						100			56
56.01	CARDIAC REHABILITATION									56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	529	463		95	19680		264		61
62	OBSERVATION BEDS (NON-DISTINC									62
	OTHER REIMBURSABLE COST CENTERS									
71	HOME HEALTH AGENCY									71
	SPECIAL PURPOSE COST CENTERS									
95	SUBTOTALS	4052	3917	14729	995	89291	100	2382	480	95
	NONREIMBURSABLE COST CENTERS									
96	GIFT, FLOWER, COFFEE SHOP & C									96
98	PHYSICIANS' PRIVATE OFFICES	195	278		139	23184		236		98
98.02	INDEPENDENT LIVING		18		26					98.02
98.03	MEALS ON WHEELS			878						98.03
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	COST TO BE ALLOC PER B PT I	124189	438871	278800	401076	756668	895521	361985	76121	103
104	UNIT COST MULT WS B PT I	29.241582		17.863779		6.727433		138.267762		104
104	UNIT COST MULT-WS B PT I		104.170662		345.755172		8955.210000		158.585417	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	14191	10603	29161	13349	16668	23597	20882	2898	107
108	UNIT COST MULT WS B PT III	3.341417		1.868456		.148193		7.976318		108
108	UNIT COST MULT-WS B PT III		2.516734		11.507759		235.970000		6.037500	108

COST ALLOCATION STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

	GENERAL SERVICE COST CENTERS	
3	NEW CAP REL COSTS-BLDG & FIXT	3
4	NEW CAP REL COSTS-MVBLE EQUIP	4
5	EMPLOYEE BENEFITS	5
6	ADMINISTRATIVE & GENERAL	6
7	MAINTENANCE & REPAIRS	7
8	OPERATION OF PLANT	8
9	LAUNDRY & LINEN SERVICE	9
10	HOUSEKEEPING	10
11	DIETARY	11
12	CAFETERIA	12
14	NURSING ADMINISTRATION	14
16	PHARMACY	16
17	MEDICAL RECORDS & LIBRARY	17
18	SOCIAL SERVICE	18
	INPATIENT ROUTINE SERV COST CENTERS	
25	ADULTS & PEDIATRICS	25
	ANCILLARY SERVICE COST CENTERS	
37	OPERATING ROOM	37
40	ANESTHESIOLOGY	40
41	RADIOLOGY-DIAGNOSTIC	41
44	LABORATORY	44
49	RESPIRATORY THERAPY	49
50	PHYSICAL THERAPY	50
51	OCCUPATIONAL THERAPY	51
52	SPEECH PATHOLOGY	52
53	ELECTROCARDIOLOGY	53
55	MEDICAL SUPPLIES CHARGED TO P	55
56	DRUGS CHARGED TO PATIENTS	56
56.01	CARDIAC REHABILITATION	56.01
	OUTPATIENT SERVICE COST CENTERS	
60	CLINIC	60
61	EMERGENCY	61
62	OBSERVATION BEDS (NON-DISTINC	62
	OTHER REIMBURSABLE COST CENTERS	
71	HOME HEALTH AGENCY	71
	SPECIAL PURPOSE COST CENTERS	
95	SUBTOTALS	95
	NONREIMBURSABLE COST CENTERS	
96	GIFT, FLOWER, COFFEE SHOP & C	96
98	PHYSICIANS' PRIVATE OFFICES	98
98.02	INDEPENDENT LIVING	98.02
98.03	MEALS ON WHEELS	98.03
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	2944521		2944521		2944521	25
	ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM	717797		717797		717797	37
40	ANESTHESIOLOGY	292939		292939		292939	40
41	RADIOLOGY-DIAGNOSTIC	1662924		1662924		1662924	41
44	LABORATORY	1063480		1063480		1063480	44
49	RESPIRATORY THERAPY	523494		523494		523494	49
50	PHYSICAL THERAPY	940259		940259		940259	50
51	OCCUPATIONAL THERAPY						51
52	SPEECH PATHOLOGY						52
53	ELECTROCARDIOLOGY	30898		30898		30898	53
55	MEDICAL SUPPLIES CHARGED TO	792812		792812		792812	55
56	DRUGS CHARGED TO PATIENTS	895521		895521		895521	56
56.01	CARDIAC REHABILITATION	37188		37188		37188	56.01
	OUTPATIENT SERVICE COST CENTERS						
60	CLINIC						60
61	EMERGENCY	1435781		1435781		1435781	61
62	OBSERVATION BEDS (NON-DISTI	162663		162663		162663	62
	OTHER REIMBURSABLE COST CENTERS						
101	SUBTOTAL	11500277		11500277		11500277	101
102	LESS OBSERVATION BEDS	162663		162663		162663	102
103	TOTAL	11337614		11337614		11337614	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I (CONT)

	COST CENTER DESCRIPTION	CHARGES INPATIENT 6	CHARGES OUTPATIENT 7	CHARGES TOTAL 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11	
	INPATIENT ROUTINE SERV COST CENTERS							
25	ADULTS & PEDIATRICS	1625104		1625104				25
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	176309	604677	780986	.919091	.919091	.919091	37
40	ANESTHESIOLOGY	112176	247979	360155	.813369	.813369	.813369	40
41	RADIOLOGY-DIAGNOSTIC	1008581	3936917	4945498	.336250	.336250	.336250	41
44	LABORATORY	1665894	3553057	5218951	.203773	.203773	.203773	44
49	RESPIRATORY THERAPY	339240	305649	644889	.811758	.811758	.811758	49
50	PHYSICAL THERAPY	194398	1362232	1556630	.604035	.604035	.604035	50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	110990	238073	349063	.088517	.088517	.088517	53
55	MEDICAL SUPPLIES CHARGED TO	1588947	849051	2437998	.325190	.325190	.325190	55
56	DRUGS CHARGED TO PATIENTS	1069450	293290	1362740	.657147	.657147	.657147	56
56.01	CARDIAC REHABILITATION		75500	75500	.492556	.492556	.492556	56.01
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
61	EMERGENCY	239500	1721801	1961301	.732055	.732055	.732055	61
62	OBSERVATION BEDS (NON-DISTI	38995	208772	247767	.656516	.656516	.656516	62
	OTHER REIMBURSABLE COST CENTERS							
101	SUBTOTAL	8169584	13396998	21566582				101
102	LESS OBSERVATION BEDS							102
103	TOTAL	8169584	13396998	21566582				103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V O/P	[XX]	HOSPITAL (14-1331)	[ ]	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 1	PART I COL. 9 1.01	PART II COL. 9 1.02	PROGRAM CHARGES: OUTPATIENT AMBULATORY SURGICAL CENTER 2	OUTPATIENT RADIOLOGY 3	OTHER OUTPATIENT DIAGNOSTIC 4	
	ANCILLARY SERVICE COST CENTERS							
37	OPERATING ROOM	.919091	.919091	.919091				37
40	ANESTHESIOLOGY	.813369	.813369	.813369				40
41	RADIOLOGY-DIAGNOSTIC	.336250	.336250	.336250				41
44	LABORATORY	.203773	.203773	.203773				44
49	RESPIRATORY THERAPY	.811758	.811758	.811758				49
50	PHYSICAL THERAPY	.604035	.604035	.604035				50
51	OCCUPATIONAL THERAPY							51
52	SPEECH PATHOLOGY							52
53	ELECTROCARDIOLOGY	.088517	.088517	.088517				53
55	MEDICAL SUPPLIES CHARGED TO PAT	.325190	.325190	.325190				55
56	DRUGS CHARGED TO PATIENTS	.657147	.657147	.657147				56
56.01	CARDIAC REHABILITATION	.492556	.492556	.492556				56.01
	OUTPATIENT SERVICE COST CENTERS							
60	CLINIC							60
61	EMERGENCY	.732055	.732055	.732055				61
62	OBSERVATION BEDS (NON-DISTINCT	.656516	.656516	.656516				62
	OTHER REIMBURSABLE COST CENTERS							
65.01	AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03	AMBULANCE SERVICES (4TH PERIOD)							65.03
101	SUBTOTAL							101
102	CRNA CHARGES							102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104	NET CHARGES							104

PART VI VACCINE COST APPORTIONMENT

		1	
1	DRUGS CHARGED TO PATIENTS RATIO OF COST TO CHARGES	.657147	1
2	VACCINE CHARGES (OTHER THAN HEPATITIS B)		2
2.01	VACCINE CHARGES - HEPATITIS B		2.01
3	VACCINE COSTS (OTHER THAN HEPATITIS B)		3
3.01	VACCINE COSTS - HEPATITIS B		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK	[ ]	TITLE V - O/P	[XX]	HOSPITAL (14-1331)	[ ]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[ ]	SUB I	[ ]	NF
BOXES	[ ]	TITLE XIX O/P	[ ]	SUB II	[ ]	S/B-SNF
			[ ]	SUB III	[ ]	S/B-NF
			[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	PROGRAM CHARGES ALL OTHER (1) (SEE INSTRU.) 5	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.01	PROGRAM CHARGES ALL OTHER (SEE INSTRU.) 5.02	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.03	PROGRAM CHARGES PPS SERVICES (SEE INSTRU.) 5.04	PROGRAM COST OUTPATIENT AMBULATORY SURGICAL CENTER 6	PROGRAM COST OUTPATIENT RADIOLOGY 7	PROGRAM COST OTHER OUTPATIENT DIAGNOSTIC 8	
	ANCILLARY SERVICE COST CENTERS									
37	OPERATING ROOM	177188								37
40	ANESTHESIOLOGY	92952								40
41	RADIOLOGY-DIAGNOSTIC	1598594								41
44	LABORATORY	1582473								44
49	RESPIRATORY THERAPY	56831								49
50	PHYSICAL THERAPY	459307								50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY	80106								53
55	MEDICAL SUPPLIES CHARGED TO PA	335406								55
56	DRUGS CHARGED TO PATIENTS	181570								56
56.01	CARDIAC REHABILITATION	55500								56.01
	OUTPATIENT SERVICE COST CENTERS									
60	CLINIC									60
61	EMERGENCY	445999								61
62	OBSERVATION BEDS (NON-DISTINCT	143164								62
	OTHER REIMBURSABLE COST CENTERS									
65.01	AMBULANCE SERVICES (2ND PERIOD									65.01
65.02	AMBULANCE SERVICES (3RD PERIOD									65.02
65.03	AMBULANCE SERVICES (4TH PERIOD									65.03
101	SUBTOTAL	5209090								101
102	CRNA CHARGES									102
103	PBP CLINIC LAB									103
104	NET CHARGES	5209090								104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
PARTS V & VI

CHECK APPLICABLE BOXES					
[ ]	TITLE V O/P	[XX]	HOSPITAL (14-1331)	[ ]	SNF
[XX]	TITLE XVIII PT B	[ ]	SUB I	[ ]	NF
[ ]	TITLE XIX O/P	[ ]	SUB II	[ ]	S/B-SNF
		[ ]	SUB III	[ ]	S/B-NF
		[ ]	SUB IV	[ ]	ICF/MR

	COST CENTER DESCRIPTION	ALL OTHER (COLS 1x5) 9	PROGRAM COST PPS SERVICES (COLUMNS 1.01x5.01) 9.01	ALL OTHER (COLUMNS 1.01x5.02) 9.02	PPS SERVICES (COLUMNS 1.01x5.03 9.03	PPS SERVICES (COLUMNS 1.01x5.04 9.04	HOSPITAL I/P PART B CHARGES (SEE INSTRU.) 10	HOSPITAL I/P PART B COST (COLUMNS 1.02x10) 11	
	ANCILLARY SERVICE COST CENTERS								
37	OPERATING ROOM	162852							37
40	ANESTHESIOLOGY	75604							40
41	RADIOLOGY-DIAGNOSTIC	537527							41
44	LABORATORY	322465							44
49	RESPIRATORY THERAPY	46133							49
50	PHYSICAL THERAPY	277438							50
51	OCCUPATIONAL THERAPY								51
52	SPEECH PATHOLOGY								52
53	ELECTROCARDIOLOGY	7091							53
55	MEDICAL SUPPLIES CHARGED TO PAT	109071							55
56	DRUGS CHARGED TO PATIENTS	119318							56
56.01	CARDIAC REHABILITATION	27337							56.01
	OUTPATIENT SERVICE COST CENTERS								
60	CLINIC								60
61	EMERGENCY	326496							61
62	OBSERVATION BEDS (NON-DISTINCT	93989							62
	OTHER REIMBURSABLE COST CENTERS								
65.01	AMBULANCE SERVICES (2ND PERIOD)								65.01
65.02	AMBULANCE SERVICES (3RD PERIOD)								65.02
65.03	AMBULANCE SERVICES (4TH PERIOD)								65.03
101	SUBTOTAL	2105321							101
102	CRNA CHARGES								102
103	LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS								103
104	NET CHARGES	2105321							104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS	HOSPITAL (OTHER) (14-1331) 1	SUB I 1	SUB II 1	SUB III 1	SUB IV 1	SNF 1	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3581						1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	2801						2
3	PRIVATE ROOM DAYS (EXCLUDING SWING BED PRIVATE ROOM DAYS)							3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2801						4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	361						5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	361						6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	29						7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	29						8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1974						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	361						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	361						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) (14-1331)	SUB I	SUB II	SUB III	SUB IV	SNF	
	SWING BED ADJUSTMENT	1	1	1	1	1	1	
17	MEDICARE RATE FOR SWING BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						19
20	MEDICAID RATE FOR SWING BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.89						20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2944521						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	2868						24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	2868						25
26	TOTAL SWING-BED COST	608007						26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2336514						27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1341100						28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1341100						30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.742237						31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	478.79						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	2336514						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) (14-1331)	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	834.17					38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1646652					39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1646652					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) (14-1331)	SUB I	SUB II	SUB III	SUB IV	
		1	1	1	1	1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1808448					48
49	TOTAL PROGRAM INPATIENT COSTS	3455100					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) (14-1331)	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	301135	60
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	301135	61
62	TOTAL MEDICARE SWING BED SNF INPATIENT ROUTINE COSTS	602270	62
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		63
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		64
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS		65

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

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

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

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

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

	HOSPITAL (OTHER) (14-1331)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
PART IV - COMPUTATION OF OBSERVATION BED COST						
83 TOTAL OBSERVATION BEDS	195					83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	834.17					84
85 OBSERVATION BED COST	162663					85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

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

[XX] HOSPITAL (14-1331)
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

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

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS		1231836		25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.919091	97998	90069	37
40	ANESTHESIOLOGY	.813369	58532	47608	40
41	RADIOLOGY-DIAGNOSTIC	.336250	741786	249426	41
44	LABORATORY	.203773	1157136	235793	44
49	RESPIRATORY THERAPY	.811758	213556	173356	49
50	PHYSICAL THERAPY	.604035	86727	52386	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.088517	78899	6984	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.325190	1044235	339575	55
56	DRUGS CHARGED TO PATIENTS	.657147	684314	449695	56
56.01	CARDIAC REHABILITATION	.492556			56.01
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC				60
61	EMERGENCY	.732055	193341	141536	61
62	OBSERVATION BEDS (NON-DISTINCT	.656516	33541	22020	62
	OTHER REIMBURSABLE COST CENTERS				
101	TOTAL		4390065	1808448	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		4390065		103

WORKSHEET D-4

INPATIENT ANCILLARY COST APPORTIONMENT

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

[ ] HOSPITAL
[ ] SUB I
[ ] SUB II
[ ] SUB III
[ ] SUB IV

[ ] SNF
[ ] NF
[XX] S/B-SNF (14-Z331)
[ ] S/B-NF
[ ] ICF/MR

[ ] PPS
[ ] TEFRA
[XX] OTHER

	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
25	ADULTS & PEDIATRICS				25
	ANCILLARY SERVICE COST CENTERS				
37	OPERATING ROOM	.919091			37
40	ANESTHESIOLOGY	.813369			40
41	RADIOLOGY DIAGNOSTIC	.336250	30109	10124	41
44	LABORATORY	.203773	140346	28599	44
49	RESPIRATORY THERAPY	.811758	51135	41509	49
50	PHYSICAL THERAPY	.604035	91078	55014	50
51	OCCUPATIONAL THERAPY				51
52	SPEECH PATHOLOGY				52
53	ELECTROCARDIOLOGY	.088517	2370	210	53
55	MEDICAL SUPPLIES CHARGED TO PAT	.325190	195866	63694	55
56	DRUGS CHARGED TO PATIENTS	.657147	145692	95741	56
56.01	CARDIAC REHABILITATION	.492556			56.01
	OUTPATIENT SERVICE COST CENTERS				
60	CLINIC				60
61	EMERGENCY	.732055			61
62	OBSERVATION BEDS (NON DISTINCT	.656516			62
	OTHER REIMBURSABLE COST CENTERS				
101	TOTAL		656596	294891	101
102	LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103	NET CHARGES		656596		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1331) 1	HOSPITAL (14-1331) 1.01	HOSPITAL (14-1331) 1.02	
1	MEDICAL AND OTHER SERVICES	2105321			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	2105321			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	2126374			17
17.01	TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART B

PART B MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL (14-1331) I	HOSPITAL (14-1331) 1.01	HOSPITAL (14-1331) 1.02	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	DEDUCTIBLES				18
18.01	COINSURANCE	763066			18.01
19	SUBTOTAL	1363308			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	1363308			23
24	PRIMARY PAYER PAYMENTS				24
25	SUBTOTAL	1363308			25
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
26	COMPOSITE RATE ESRD				26
27	BAD DEBTS	105960			27
27.01	REDUCED REIMBURSABLE BAD DEBTS	105960			27.01
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	99487			27.02
28	SUBTOTAL	1469268			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	1469268			32
33	SEQUESTRATION ADJUSTMENT				33
34	INTERIM PAYMENTS	1576629			34
34.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)				34.01
35	BALANCE DUE PROVIDER/PROGRAM	-107361			35
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2				36

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1

HOSPITAL (14-1331)

DESCRIPTION			INPATIENT PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				3007780		1551429	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.				NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.01	01/16/2008	22800	01/16/2008	25200	3.01
	PROGRAM TO PROVIDER	.02					3.02
		.03					3.03
		.04					3.04
		.05					3.05
		.50					3.50
	PROVIDER TO PROGRAM	.51					3.51
		.52		NONE		NONE	3.52
		.53					3.53
		.54					3.54
SUBTOTAL		.99		22800		25200	3.99
4 TOTAL INTERIM PAYMENTS				3030580		1576629	4
TO BE COMPLETED BY INTERMEDIARY							
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM TO PROVIDER	.01					5.01
		.02		NONE		NONE	5.02
		.03					5.03
	PROVIDER TO PROGRAM	.50					5.50
		.51		NONE		NONE	5.51
		.52					5.52
SUBTOTAL		.99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO PROVIDER	.01		177310			6.01
	PROVIDER TO PROGRAM	.02				-107361	6.02
7 TOTAL MEDICARE PROGRAM LIABILITY				3207890		1469268	7

NAME OF INTERMEDIARY: _____

INTERMEDIARY NUMBER: _____

SIGNATURE OF AUTHORIZED PERSON: _____

DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
SWING BED SKILLED NURSING FACILITY (14-Z331)

WORKSHEET E-1

DESCRIPTION		INPATIENT PART A MM/DD/YYYY 1	INPATIENT PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER			880600			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.			NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01	01/16/2008	27500			3.01
	PROGRAM .02					3.02
	TO .03				NONE	3.03
	PROVIDER .04					3.04
	.05					3.05
	.50					3.50
	PROVIDER .51					3.51
	TO .52		NONE		NONE	3.52
	PROGRAM .53					3.53
	.54					3.54
SUBTOTAL	.99		27500			3.99
4 TOTAL INTERIM PAYMENTS			908100			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		-14163			6.02
7 TOTAL MEDICARE PROGRAM LIABILITY			893937			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-Z331)	S/B SNF PART B (14-Z331)	--- TITLE XIX --- S/B SNF	S/B NF	
		1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF		608293				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF						2
3	ANCILLARY SERVICES		297840				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						4
5	PROGRAM DAYS		722				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM						6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION SNF OPTIONAL METHOD ONLY						7
8	SUBTOTAL		906133				8
9	PRIMARY PAYER PAYMENTS						9
10	SUBTOTAL		906133				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)						11
12	SUBTOTAL		906133				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		12196				13
14	80% OF PART B COSTS						14
15	SUBTOTAL		893937				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		893937				18
19	SEQUESTRATION ADJUSTMENT						19
20	INTERIM PAYMENTS		908100				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						20.01
21	BALANCE DUE PROVIDER/PROGRAM		-14163				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 (14-1331)	SUB I	SUB II	SUB III	SUB IV	SNF I	
1	INPATIENT SERVICES	3455100						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	3455100						4
5	PRIMARY PAYER PAYMENTS							5
6	TOTAL COST	3489651						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 (14-1331)	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	3489651						19
20	DEDUCTIBLES	344512						20
21	EXCESS REASONABLE COST							21
22	SUBTOTAL	3145139						22
23	COINSURANCE	1744						23
24	SUBTOTAL	3143395						24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	64495						25
25.01	REDUCED REIMBURSABLE BAD DEBTS	64495						25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	59685						25.02
26	SUBTOTAL	3207890						26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION							27
28	OTHER ADJUSTMENTS							28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS							29
30	SUBTOTAL	3207890						30
31	SEQUESTRATION ADJUSTMENT							31
32	INTERIM PAYMENTS	3030580						32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							32.01
33	BALANCE DUE PROVIDER/PROGRAM	177310						33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2							34

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

WORKSHEET E-3
PART III

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

		HOSPITAL (14-1331) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES							1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							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							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							23
	PROSPECTIVE PAYMENT AMOUNT							
24	OTHER THAN OUTLIER PAYMENTS	108275						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	108275						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31							32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

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

WORKSHEET E-3
PART III

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

		HOSPITAL (14-1331) (PPS)	SUB I	SUB II	SUB III	SUB IV	NF I	
		1	1	1	1	1	1	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST							34
35	SUBTOTAL							35
36	COINSURANCE							36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,							37
38	REIMBURSABLE BAD DEBTS							38
38.01	REDUCED REIMBURSABLE BAD DEBTS							38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)							38.02
39	UTILIZATION REVIEW							39
40	SUBTOTAL							40
41	INPATIENT ROUTINE SERVICE COST							41
42	MEDICARE INPATIENT ROUTINE CHARGES							42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							44
45	RATIO OF LINE 43 TO LINE 44							45
46	TOTAL CUSTOMARY CHARGES							46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION							49
50	OTHER ADJUSTMENTS							50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS							51
52	SUBTOTAL							52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT							53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS							54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER							55
56	SEQUESTRATION ADJUSTMENT							56
57	INTERIM PAYMENTS							57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)							57.01
58	BALANCE DUE PROVIDER/PROGRAM							58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2							59

BALANCE SHEET

	ASSETS	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	494246				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	2819841				4
5	OTHER RECEIVABLES					5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-341000				6
7	INVENTORY	108170				7
8	PREPAID EXPENSES	194924				8
9	OTHER CURRENT ASSETS	19214				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS	3295395				11
	FIXED ASSETS					
12	LAND	3114				12
12.01	ACCUMULATED DEPRECIATION					12.01
13	LAND IMPROVEMENTS	720994				13
13.01	ACCUMULATED DEPRECIATION	-349040				13.01
14	BUILDINGS	7554136				14
14.01	ACCUMULATED DEPRECIATION	-2358627				14.01
15	LEASEHOLD IMPROVEMENTS					15
15.01	ACCUMULATED AMORTIZATION					15.01
16	FIXED EQUIPMENT	6000564				16
16.01	ACCUMULATED DEPRECIATION	-2022094				16.01
17	AUTOMOBILES AND TRUCKS					17
17.01	ACCUMULATED DEPRECIATION					17.01
18	MAJOR MOVABLE EQUIPMENT	4356710				18
18.01	ACCUMULATED DEPRECIATION	-2545806				18.01
19	MINOR EQUIPMENT DEPRECIABLE					19
19.01	ACCUMULATED DEPRECIATION					19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE					20
21	TOTAL FIXED ASSETS	11359951				21
	OTHER ASSETS					
22	INVESTMENTS	5994065				22
23	DEPOSITS ON LEASES					23
24	DUE FROM OWNERS/OFFICERS					24
25	OTHER ASSETS	200327				25
26	TOTAL OTHER ASSETS	6194392				26
27	TOTAL ASSETS	20849738				27

	LIABILITIES AND FUND BALANCES	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
	CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	514785				28
29	SALARIES, WAGES & FEES PAYABLE	775694				29
30	PAYROLL TAXES PAYABLE					30
31	NOTES & LOANS PAYABLE (SHORT TERM)	618479				31
32	DEFERRED INCOME					32
33	ACCELERATED PAYMENTS					33
34	DUE TO OTHER FUNDS					34
35	OTHER CURRENT LIABILITIES	178000				35
36	TOTAL CURRENT LIABILITIES	2086958				36
	LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE					37
38	NOTES PAYABLE	10005000				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	2246303				41
42	TOTAL LONG TERM LIABILITIES	12251303				42
43	TOTAL LIABILITIES	14338261				43
	CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	6511477				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	6511477				51
52	TOTAL LIABILITIES AND FUND BALANCES	20849738				52

STATEMENT OF CHANGES IN FUND BALANCES

		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
1	FUND BALANCES AT BEGINNING OF PERIOD	7317367				1
2	NET INCOME (LOSS)	-732444				2
3	TOTAL	6584923				3
4	ADDITIONS (CREDIT ADJUSTMENTS)					4
5	RESTRICTED CONTRIBUTIONS	868				5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS	868				10
11	SUBTOTAL	6585791				11
12	DEDUCTIONS (DEBIT ADJUSTMENTS)					12
13	RELEASED FROM RESTRICTION	74314				13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS	74314				18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	6511477				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	1625104		1625104	1
2	SUBPROVIDER I				2
4	SWING BED - SNF	167586		167586	4
5	SWING BED - NF				5
6	SKILLED NURSING FACILITY				6
7	NURSING FACILITY				7
8	OTHER LONG TERM CARE				8
9	TOTAL GENERAL INPATIENT CARE SERVICES	1792690		1792690	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	1792690		1792690	16
17	ANCILLARY SERVICES	6288736	11515226	17803962	17
18	OUTPATIENT SERVICES	780775	4145094	4925869	18
19	HOME HEALTH AGENCY				19
20	AMBULANCE				20
21	CORF				21
22	ASC				22
23	HOSPICE				23
24					24
25	TOTAL PATIENT REVENUES	8862201	15660320	24522521	25

PART II - OPERATING EXPENSES

		1	2	
26	OPERATING EXPENSES		15604371	26
27	ADD (SPECIFY)			27
28				28
29				29
30				30
31				31
32				32
33	TOTAL ADDITIONS			33
34	DEDUCT (SPECIFY)			34
35				35
36				36
37				37
38				38
39	TOTAL DEDUCTIONS			39
40	TOTAL OPERATING EXPENSES		15604371	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES	24522521	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	9657786	2
3	NET PATIENT REVENUES	14864735	3
4	LESS TOTAL OPERATING EXPENSES	15604371	4
5	NET INCOME FROM SERVICE TO PATIENTS	-739636	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	44370	6
7	INCOME FROM INVESTMENTS		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	53444	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	296541	15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	53663	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	1226	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	17823	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	GAIN ON INVESTMENTS NET		24
24.01	OTHER INCOME	56132	24.01
24.02	RESTRICTED CONTRIBUTIONS	74314	24.02
25	TOTAL OTHER INCOME	597513	25
26	TOTAL	-142123	26
27	LOSS ON INVESTMENTS - NET	584088	27
27.01	OTHER LOSSES	6233	27.01
28			28
29			29
30	TOTAL OTHER EXPENSES	590321	30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-732444	31