EXHIBIT 3A

TITLE	*MEDICAID ELIGIBLE DAYS FOR A DSH ELIGIBLE HOSPITAL*
PROVIDER NAME	
CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
WS S-2, PT. I, LINE #	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMNS 10 &12	
TOTAL COLUMN 11	

PATIENT CLAIM INFORMATION							
PATIENT LAST NAME	*PATIENT FIRST NAME*	*DATE OF SERVICE - FROM*	*DATE OF SERVICE - TO*	*PATIENT ACCOUNT NUMBER*	*MEDICAL RECORD NUMBER*	*MEDICAID NUMBER*	*STATE ELIGIBILITY CODE*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*

MEDICAID DAYS				INSURANCE OR OTHER PAYER NAME		MEDICARE ELIGIBILITY			
WKST S-2, PART I COLUMN NUMBER	*ELIGIBLE DAYS*	*LABOR & DELIVERY ROOM DAYS*	*NEWBORN BABY DAYS*	*PRIMARY*	*SECONDARY*	*A/B INDICATOR*	*START DATE*	*END DATE*	*COMMENTS*
9	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*