

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
 FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
 THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
 (42 USC 1395g).

WORKSHEET S
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1303	I	FROM 7/ 1/2006	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2007	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/27/2007 TIME 16:10

PART I - CERTIFICATION

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 BY 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: ST. VINCENT JENNINGS HOSPITAL 15-1303 FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2006 AND ENDING 6/30/2007 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 INFORMATION
 DATE: 11/27/2007 TIME 16:10

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4		
1	HOSPITAL	0	150,174	-102,508	0	0
3	SWING BED - SNF	0	123,676	0	0	0
9	RHC	0	0	4,046	0	0
100	TOTAL	0	273,850	-98,462	0	0

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 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: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 301 HENRY STREET P.O. BOX:
 1.01 CITY: NORTH VERNON STATE: IN ZIP CODE: 47265- COUNTY: JENNINGS

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-1303	2.01	7/ 1/1996	N	O	N
04.00	SWING BED - SNF	15-2303		7/ 5/1991	N	O	N
14.00	HOSPITAL-BASED RHC	15-3991		1/ 1/1996	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2006 TO: 6/30/2007
 18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER
 19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION
 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT 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. Y
 21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N
 21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).
 21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y
 21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
 21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2
 21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO.
 22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N
 23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N
 23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE / /
 23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /
 24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2.
 25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N
 25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4? N
 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.
 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. N
 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE 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)
 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS 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)
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. 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. 0
 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 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. Y 7/ 5/1991

28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1	2	3	4
		-----	-----	-----	-----
		0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		
	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 INSTR)	%	Y/N		
28.03	STAFFING	0.00%			
28.04	RECRUITMENT	0.00%			
28.05	RETENTION	0.00%			
28.06	TRAINING	0.00%			
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?	N			
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y			
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N			
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N			
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE 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).	N			
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE 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	N			
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
	MISCELLANEOUS COST REPORT INFORMATION				
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N			
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	N			
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N			
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N	
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N	

TITLE XIX INPATIENT SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? Y
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10?
 IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER.
 IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE Y

40.01 NAME: FI/CONTRACTOR NAME FI/CONTRACTOR #
 40.02 STREET: P.O. BOX:
 40.03 CITY: STATE: ZIP CODE: -

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
 45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
 46 IF YOU ARE PARTICIPATING IN THE NHCQM DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N

52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N

53 IF YOU ARE 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. 0

53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 64,031
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0

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. N

55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE	Y OR N	LIMIT	Y OR N	FEES
56	7/ 1/2006	N	0.00		0

56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE. 0.00 0

56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0

56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY. 0.00 0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

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% FEDERAL 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. N

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 "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). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

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) N

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). 0

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2,01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,125	48,288.00			836	129
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						646	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125				1,482	129
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	25	9,125				1,482	129
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
24 RURAL HEALTH CLINIC						5,677	11,898
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION NOT ADMITTED 5.02	BEDS	O/P VISITS / TOTAL ALL PATS 6	TRIPS / TOTAL OBSERVATION ADMITTED 6.01	OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES / TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS				1,313				
2 HMO								
2 01 HMO - (IRF PPS SUBPROVIDER)								
3 ADULTS & PED-SB SNF				646				
4 ADULTS & PED-SB NF				34				
5 TOTAL ADULTS AND PEDS				1,993				
6 INTENSIVE CARE UNIT								
7 CORONARY CARE UNIT								
8 BURN INTENSIVE CARE UNIT								
9 SURGICAL INTENSIVE CARE UNIT								
11 NURSERY								
12 TOTAL				1,993				
13 RPCH VISITS								
14 SUBPROVIDER								
15 SKILLED NURSING FACILITY								
16 NURSING FACILITY								
16 01 ICF/MR								
17 OTHER LONG TERM CARE								
18 HOME HEALTH AGENCY								
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE								
23 CORF								
24 RURAL HEALTH CLINIC				45,866				
25 TOTAL								
26 OBSERVATION BED DAYS				415	37	378		
27 AMBULANCE TRIPS								
27 01 AMBULANCE TRIPS								
27 02 AMBULANCE TRIPS								
28 EMPLOYEE DISCOUNT DAYS				19				
28 01 EMP DISCOUNT DAYS -IRF								

COMPONENT	I & R FTES NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13 289	TITLE XIX 14 45	TOTAL ALL PATIENTS 15 569
1 ADULTS & PEDIATRICS							
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		164.21			289	45	569
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							
18 HOME HEALTH AGENCY							
20 AMBULATORY SURGICAL CENTER (

COMPONENT	I & R FTES NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV --- NONPAID WORKERS 11	----- TITLE V 12	DISCHARGES TITLE XVIII 13	----- TITLE XIX 14	TOTAL ALL PATIENTS 15
21 HOSPICE							
23 CORF							
24 RURAL HEALTH CLINIC		51.62					
25 TOTAL		215.83					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION
 1 STREET: 325 HENRY STREET
 1.01 CITY: NORTH VERNON STATE: IN ZIP CODE: 47265 COUNTY: JENNINGS
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS: GRANT AWARD DATE
 3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT) 1 2
 4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) // /
 5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT) // /
 6 APPALACHIAN REGIONAL COMMISSION // /
 7 LOOK-ALIKES // /
 8 OTHER (SPECIFY) // /

PHYSICIAN INFORMATION: PHYSICIAN BILLING
 9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT ALI NAME NUMBER
 9.01 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT BENGERO 01057500A
 9.02 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT CLIBURN 01035815A
 9.03 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT JNIEDI 02002820A
 9.04 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT WAHEED 01059377A
 9.05 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT SCANDRETT 01052927A
 9.06 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT SCHUCK 01051063A
 9.07 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT STANLEY 01051065A

PHYSICIAN NAME HOURS OF SUPERVISION
 10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD STANLEY 2,080.00
 10.01 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD SCHUCK 2,080.00

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) N

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC	1100	1730	600	1800	600	1800	600	1800	600	1800	600	1800	700	1700

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

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES.

15 PROVIDER NAME: PROVIDER NUMBER:

TITLE V TITLE XVIII TITLE XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR SERVICES RENDERED ON OR AFTER 7/1/2001? IF YES, SEE INSTRUCTIONS.

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
1	0100	OLD CAP REL COSTS-BLDG & FIXT					
2	0200	OLD CAP REL COSTS-MVBLE EQUIP					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		362,185	362,185	234,653	596,838
3.01	0301	NEW CAP REL COSTS-BLDG & FIXT					
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		899,101	899,101	-237,235	661,866
4.01	0401	NEW CAP REL COSTS-MVBLE EQUIP					
5	0500	EMPLOYEE BENEFITS	100,282	2,733,475	2,833,757	-737	2,833,020
6	0600	ADMINISTRATIVE & GENERAL	629,325	1,554,945	2,184,270	1,924	2,186,194
7	0700	MAINTENANCE & REPAIRS					
8	0800	OPERATION OF PLANT	135,362	657,104	792,466	-136	792,330
9	0900	LAUNDRY & LINEN SERVICE		91,716	91,716	-155	91,561
10	1000	HOUSEKEEPING	293,560	112,179	405,739	-573	405,166
11	1100	DIETARY	115,765	53,227	168,992	-111,844	57,148
12	1200	CAFETERIA				111,423	111,423
13	1300	MAINTENANCE OF PERSONNEL					
14	1400	NURSING ADMINISTRATION	122,696	3,291	125,987		125,987
15	1500	CENTRAL SERVICES & SUPPLY	81,361	9,532	90,893	-121	90,772
16	1600	PHARMACY	132,685	437,820	570,505	-438	570,067
17	1700	MEDICAL RECORDS & LIBRARY	540,769	366,811	907,580	-3,309	904,271
18	1800	SOCIAL SERVICE					
20	2000	NONPHYSICIAN ANESTHETISTS					
21	2100	NURSING SCHOOL					
22	2200	I&R SERVICES-SALARY & FRINGES APPRVD					
23	2300	I&R SERVICES-OTHER PRGM COSTS APPRVD					
24	2400	PARAMED ED PRGM					
25	2500	INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	996,593	94,542	1,091,135	-55,193	1,035,942
26	2600	INTENSIVE CARE UNIT					
27	2700	CORONARY CARE UNIT					
28	2800	BURN INTENSIVE CARE UNIT					
29	2900	SURGICAL INTENSIVE CARE UNIT					
31	3100	SUBPROVIDER					
33	3300	NURSERY					
34	3400	SKILLED NURSING FACILITY					
35	3500	NURSING FACILITY					
35.01	3510	ICF/MR					
36	3600	OTHER LONG TERM CARE					
37	3700	ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	863,539	236,067	1,099,606	-13,041	1,086,565
38	3800	RECOVERY ROOM					
39	3900	DELIVERY ROOM & LABOR ROOM					
40	4000	ANESTHESIOLOGY					
41	4100	RADIOLOGY-DIAGNOSTIC	850,015	775,705	1,625,720	-30,875	1,594,845
42	4200	RADIOLOGY-THERAPEUTIC					
43	4300	RADIOISOTOPE					
44	4400	LABORATORY	659,294	725,794	1,385,088	-22,040	1,363,048
45	4500	PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700	BLOOD STORING, PROCESSING & TRANS.					
48	4800	INTRAVENOUS THERAPY					
49	4900	RESPIRATORY THERAPY		22,800	22,800	29,072	51,872
50	5000	PHYSICAL THERAPY	150,273	361,551	511,824	-13,827	497,997
51	5100	OCCUPATIONAL THERAPY					
52	5200	SPEECH PATHOLOGY		3,278	3,278		3,278
53	5300	ELECTROCARDIOLOGY		24,042	24,042	10,547	34,589
54	5400	ELECTROENCEPHALOGRAPHY					
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		644,367	644,367	168,564	812,931
56	5600	DRUGS CHARGED TO PATIENTS					
57	5700	RENAL DIALYSIS					
58	5800	ASC (NON-DISTINCT PART)					
60	6000	OUTPAT SERVICE COST CNTRS					
61	6100	CLINIC					
61	6100	EMERGENCY	772,184	1,222,475	1,994,659	-66,659	1,928,000
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	2,756,515	416,464	3,172,979		3,172,979
64	6400	OTHER REIMBURS COST CNTRS					
64	6400	HOME PROGRAM DIALYSIS					
65	6500	AMBULANCE SERVICES					
66	6600	DURABLE MEDICAL EQUIP-RENTED					
67	6700	DURABLE MEDICAL EQUIP-SOLD					
69	6900	CORF					
70	7000	I&R SERVICES-NOT APPRVD PRGM					
71	7100	HOME HEALTH AGENCY					
82	8200	SPEC PURPOSE COST CENTERS					
82	8200	LUNG ACQUISITION					
83	8300	KIDNEY ACQUISITION					
84	8400	LIVER ACQUISITION					
85	8500	HEART ACQUISITION					
85.01	8510	PANCREAS ACQUISITION					
88	8800	INTEREST EXPENSE					
89	8900	UTILIZATION REVIEW-SNF					
90	9000	OTHER CAPITAL RELATED COSTS					
92	9200	AMBULATORY SURGICAL CENTER (D.P.)					
93	9300	HOSPICE					
95		SUBTOTALS	9,200,218	11,808,471	21,008,689	-0-	21,008,689
96	9600	NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
97	9700	RESEARCH					
98	9800	PHYSICIANS' PRIVATE OFFICES					
99	9900	NONPAID WORKERS					
100	7950	WIC	107,821	-89,750	18,071		18,071
100.01	7951	TOBACCO/CHILD GRANT					
100.02	7952	CLINIC	807,671	252,626	1,060,297		1,060,297
101		TOTAL	10,115,710	11,971,347	22,087,057	-0-	22,087,057

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
1	0100 OLD CAP REL COSTS-BLDG & FIXT		
2	0200 OLD CAP REL COSTS-MVBLE EQUIP		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	221,288	818,126
3.01	0301 NEW CAP REL COSTS-BLDG & FIXT		
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-15,660	646,206
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP		
5	0500 EMPLOYEE BENEFITS	243,639	3,076,659
6	0600 ADMINISTRATIVE & GENERAL	1,132,348	3,318,542
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT	-15,848	776,482
9	0900 LAUNDRY & LINEN SERVICE		91,561
10	1000 HOUSEKEEPING	-20,287	384,879
11	1100 DIETARY	-23,403	33,745
12	1200 CAFETERIA		111,423
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION		125,987
15	1500 CENTRAL SERVICES & SUPPLY		90,772
16	1600 PHARMACY		570,067
17	1700 MEDICAL RECORDS & LIBRARY	-9,013	895,258
18	1800 SOCIAL SERVICE		
20	2000 NONPHYSICIAN ANESTHETISTS		
21	2100 NURSING SCHOOL		
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD		
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD		
24	2400 PARAMED ED PRGM		
25	2500 ADULTS & PEDIATRICS	-86,876	949,066
26	2600 INTENSIVE CARE UNIT		
27	2700 CORONARY CARE UNIT		
28	2800 BURN INTENSIVE CARE UNIT		
29	2900 SURGICAL INTENSIVE CARE UNIT		
31	3100 SUBPROVIDER		
33	3300 NURSERY		
34	3400 SKILLED NURSING FACILITY		
35	3500 NURSING FACILITY		
35.01	3510 ICF/MR		
36	3600 OTHER LONG TERM CARE		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-492,137	594,428
38	3800 RECOVERY ROOM		
39	3900 DELIVERY ROOM & LABOR ROOM		
40	4000 ANESTHESIOLOGY		
41	4100 RADIOLOGY-DIAGNOSTIC	-55	1,594,790
42	4200 RADIOLOGY-THERAPEUTIC		
43	4300 RADIOISOTOPE		
44	4400 LABORATORY	-165	1,362,883
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
47	4700 BLOOD STORING, PROCESSING & TRANS.		
48	4800 INTRAVENOUS THERAPY		
49	4900 RESPIRATORY THERAPY		51,872
50	5000 PHYSICAL THERAPY	-67,002	430,995
51	5100 OCCUPATIONAL THERAPY		
52	5200 SPEECH PATHOLOGY		3,278
53	5300 ELECTROCARDIOLOGY	-24,000	10,589
54	5400 ELECTROENCEPHALOGRAPHY		
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		812,931
56	5600 DRUGS CHARGED TO PATIENTS		
57	5700 RENAL DIALYSIS		
58	5800 ASC (NON-DISTINCT PART)		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		
61	6100 EMERGENCY	-454,723	1,473,277
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC	-31,690	3,141,289
	OTHER REIMBURS COST CNTRS		
64	6400 HOME PROGRAM DIALYSIS		
65	6500 AMBULANCE SERVICES		
66	6600 DURABLE MEDICAL EQUIP-RENTED		
67	6700 DURABLE MEDICAL EQUIP-SOLD		
69	6900 CORF		
70	7000 I&R SERVICES-NOT APPRVD PRGM		
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
82	8200 LUNG ACQUISITION		
83	8300 KIDNEY ACQUISITION		
84	8400 LIVER ACQUISITION		
85	8500 HEART ACQUISITION		
85.01	8510 PANCREAS ACQUISITION		
88	8800 INTEREST EXPENSE		-0-
89	8900 UTILIZATION REVIEW-SNF		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
92	9200 AMBULATORY SURGICAL CENTER (D.P.)		
93	9300 HOSPICE		
95	SUBTOTALS	356,416	21,365,105
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
97	9700 RESEARCH		
98	9800 PHYSICIANS' PRIVATE OFFICES		
99	9900 NONPAID WORKERS		
100	7950 WIC	129,137	147,208
100.01	7951 TOBACCO/CHILD GRANT		
100.02	7952 CLINIC		1,060,297
101	TOTAL	485,553	22,572,610

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
1	OLD CAP REL COSTS-BLDG & FIXT	0100	
2	OLD CAP REL COSTS-MVBLE EQUIP	0200	
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
3.01	NEW CAP REL COSTS-BLDG & FIXT	0301	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-MVBLE EQUIP	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
21	NURSING SCHOOL	2100	
22	I&R SERVICES-SALARY & FRINGES APPRVD	2200	
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	2300	
24	PARAMED ED PRGM	2400	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
35.01	ICF/MR	3510	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
57	RENAL DIALYSIS	5700	
58	ASC (NON-DISTINCT PART)	5800	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
64	HOME PROGRAM DIALYSIS	6400	
65	AMBULANCE SERVICES	6500	
66	DURABLE MEDICAL EQUIP-RENTED	6600	
67	DURABLE MEDICAL EQUIP-SOLD	6700	
69	CORF	6900	
70	I&R SERVICES-NOT APPRVD PRGM	7000	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
82	LUNG ACQUISITION	8200	
83	KIDNEY ACQUISITION	8300	
84	LIVER ACQUISITION	8400	
85	HEART ACQUISITION	8500	
85.01	PANCREAS ACQUISITION	8510	
88	INTEREST EXPENSE	8800	
89	UTILIZATION REVIEW-SNF	8900	
90	OTHER CAPITAL RELATED COSTS	9000	
92	AMBULATORY SURGICAL CENTER (D.P.)	9200	
93	HOSPICE	9300	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
97	RESEARCH	9700	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	WIC	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	TOBACCO/CHILD GRANT	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	CLINIC	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		SALARY	OTHER
	(1)	COST CENTER	LINE NO			
1 CAFETERIA	A	CAFETERIA	12		76,332	35,091
2 PROPERTY INSURANCE	C	NEW CAP REL COSTS-BLDG & FIXT	3			17,606
3 RT SALARIES	E	RESPIRATORY THERAPY	49		34,906	
4						
5						
6 EKG TECH TIME	G	ELECTROCARDIOLOGY	53		10,589	
7 INTEREST	H	NEW CAP REL COSTS-BLDG & FIXT	3			217,047
8 ADMINISTRATIVE AND GENERAL	I	ADMINISTRATIVE & GENERAL	6			20,188
9 MEDICAL SUPPLIES	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			168,564
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
36 TOTAL RECLASSIFICATIONS					121,827	458,496

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry. Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate. See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO	7			
1 CAFETERIA	A	DIETARY	11	76,332		35,091	
2 PROPERTY INSURANCE	C	ADMINISTRATIVE & GENERAL	6			17,606	9
3 RT SALARIES	E	ADULTS & PEDIATRICS	25	13,215			
4		OPERATING ROOM	37	11,451			
5		EMERGENCY	61	10,240			
6 EKG TECH TIME	G	LABORATORY	44	10,589			
7 INTEREST	H	NEW CAP REL COSTS-MVBLE EQUIP	4			217,047	9
8 ADMINISTRATIVE AND GENERAL	I	NEW CAP REL COSTS-MVBLE EQUIP	4			20,188	9
9 MEDICAL SUPPLIES	J	HOUSEKEEPING	10			573	
10		DIETARY	11			421	
11		CENTRAL SERVICES & SUPPLY	15			121	
12		PHARMACY	16			438	
13		MEDICAL RECORDS & LIBRARY	17			3,309	
14		ADULTS & PEDIATRICS	25			41,978	
15		OPERATING ROOM	37			1,590	
16		RADIOLOGY-DIAGNOSTIC	41			30,875	
17		LABORATORY	44			11,451	
18		RESPIRATORY THERAPY	49			5,834	
19		PHYSICAL THERAPY	50			13,827	
20		ELECTROCARDIOLOGY	53			42	
21		EMPLOYEE BENEFITS	5			737	
22		EMERGENCY	61			56,419	
23		ADMINISTRATIVE & GENERAL	6			658	
24		OPERATION OF PLANT	8			136	
25		LAUNDRY & LINEN SERVICE	9			155	
26 TOTAL RECLASSIFICATIONS				121,827		458,496	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
 EXPLANATION : CAFETERIA

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	111,423
TOTAL RECLASSIFICATIONS FOR CODE A			111,423

DECREASE			
COST CENTER	LINE	AMOUNT	
DIETARY	11	111,423	
		111,423	

RECLASS CODE: C
 EXPLANATION : PROPERTY INSURANCE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	17,606
TOTAL RECLASSIFICATIONS FOR CODE C			17,606

DECREASE			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	17,606	
		17,606	

RECLASS CODE: E
 EXPLANATION : RT SALARIES

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	RESPIRATORY THERAPY	49	34,906
2.00			0
3.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			34,906

DECREASE			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	13,215	
OPERATING ROOM	37	11,451	
EMERGENCY	61	10,240	
		34,906	

RECLASS CODE: G
 EXPLANATION : EKG TECH TIME

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	10,589
TOTAL RECLASSIFICATIONS FOR CODE G			10,589

DECREASE			
COST CENTER	LINE	AMOUNT	
LABORATORY	44	10,589	
		10,589	

RECLASS CODE: H
 EXPLANATION : INTEREST

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	217,047
TOTAL RECLASSIFICATIONS FOR CODE H			217,047

DECREASE			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-MVBLE EQUIP	4	217,047	
		217,047	

RECLASS CODE: I
 EXPLANATION : ADMINISTRATIVE AND GENERAL

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	20,188
TOTAL RECLASSIFICATIONS FOR CODE I			20,188

DECREASE			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-MVBLE EQUIP	4	20,188	
		20,188	

RECLASS CODE: J
 EXPLANATION : MEDICAL SUPPLIES

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	168,564
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
13.00			0
14.00			0
15.00			0
16.00			0
17.00			0
TOTAL RECLASSIFICATIONS FOR CODE J			168,564

DECREASE			
COST CENTER	LINE	AMOUNT	
HOUSEKEEPING	10	573	
DIETARY	11	421	
CENTRAL SERVICES & SUPPLY	15	121	
PHARMACY	16	438	
MEDICAL RECORDS & LIBRARY	17	3,309	
ADULTS & PEDIATRICS	25	41,978	
OPERATING ROOM	37	1,590	
RADIOLOGY-DIAGNOSTIC	41	30,875	
LABORATORY	44	11,451	
RESPIRATORY THERAPY	49	5,834	
PHYSICAL THERAPY	50	13,827	
ELECTROCARDIOLOGY	53	42	
EMPLOYEE BENEFITS	5	737	
EMERGENCY	61	56,419	
ADMINISTRATIVE & GENERAL	6	658	
OPERATION OF PLANT	8	136	
LAUNDRY & LINEN SERVICE	9	155	
		168,564	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND								
2	LAND IMPROVEMENTS								
3	BUILDINGS & FIXTURE								
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT								
6	MOVABLE EQUIPMENT								
7	SUBTOTAL								
8	RECONCILING ITEMS								
9	TOTAL								

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS		TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
				DONATION 3					
1	LAND	127,944						127,944	
2	LAND IMPROVEMENTS	360,055	40,774			40,774		400,829	
3	BUILDINGS & FIXTURE	13,140,276	173,058			173,058		13,313,334	
4	BUILDING IMPROVEMEN								
5	FIXED EQUIPMENT	6,144,497	452,340			452,340		6,596,837	
6	MOVABLE EQUIPMENT								
7	SUBTOTAL	19,772,772	666,172			666,172		20,438,944	
8	RECONCILING ITEMS								
9	TOTAL	19,772,772	666,172			666,172		20,438,944	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
			CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
1	OLD CAP REL COSTS-BL								
2	OLD CAP REL COSTS-MV								
3	NEW CAP REL COSTS-BL	20,438,944		20,438,944	1.000000				
3 01	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
4 01	NEW CAP REL COSTS-MV								
5	TOTAL	20,438,944		20,438,944	1.000000				

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1)
								15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	818,126						818,126
3 01	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	646,206						646,206
4 01	NEW CAP REL COSTS-MV							
5	TOTAL	1,464,332						1,464,332

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

DESCRIPTION

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1)
								15
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	362,185						362,185
3 01	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	899,101						899,101
4 01	NEW CAP REL COSTS-MV							
5	TOTAL	1,261,286						1,261,286

* All lines numbers except line 5 are to be consistent with workshseet A line numbers for capital cost centers.
 (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4.
 Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I 15-1303 I

I PERIOD: I FROM 7/ 1/2006 I TO 6/30/2007 I PREPARED 11/27/2007 I WORKSHEET A-8

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO	WKST. A-7 REF. 5
			COST CENTER			
1 INVST INCOME-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1		
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2		
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3		
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4		
5 INVESTMENT INCOME-OTHER	B	-35,178	ADMINISTRATIVE & GENERAL	6		
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES						
10 TELEVISION AND RADIO SERVICE	A	-6,338	OPERATION OF PLANT	8		
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,057,736				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	1,704,439				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-23,403	DIETARY	11		
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS						
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-9,013	MEDICAL RECORDS & LIBRARY	17		
21 NURSG SCHOOL (TUITN, FEES, BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49		
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4	-67,002	PHYSICAL THERAPY	50		
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP			UTILIZATION REVIEW-SNF	89		
29 DEPRECIATION-OLD BLDGS AND FIXTURES			OLD CAP REL COSTS-BLDG &	1		
30 DEPRECIATION-OLD MOVABLE EQUIP			OLD CAP REL COSTS-MVBLE E	2		
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3		
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4		
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20		
34 PHYSICIANS' ASSISTANT						
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51		
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52		
37 PATIENT PHONE BENEFITS	A	-572	EMPLOYEE BENEFITS	5		
38 PATIENT PHONE DEPRECIATION	A	-1,342	NEW CAP REL COSTS-BLDG &	3		9
39 PATIENT PHONE OPERATING COSTS	A	-4,046	ADMINISTRATIVE & GENERAL	6		
40 PHYSICIAN BENEFITS	A	-4,405	EMPLOYEE BENEFITS	5		
41 PHYSICIAN HOUSEKEEPING	A	-20,287	HOUSEKEEPING	10		
42 PHYSICIAN PLANT OPS	A	-9,510	OPERATION OF PLANT	8		
43 AHA DUES	A	-1,657	ADMINISTRATIVE & GENERAL	6		
44 IHA DUES	A	-161	ADMINISTRATIVE & GENERAL	6		
45 WIC GRANT	A	129,137	WIC	100		
46 ADVERTISING	A	-137	EMPLOYEE BENEFITS	5		
47 ADVERTISING	A	-73,240	ADMINISTRATIVE & GENERAL	6		
48 MISC	B	-31,690	RURAL HEALTH CLINIC	63.50		
49 MISC	B	-2,086	ADMINISTRATIVE & GENERAL	6		
49.01 MISC	B	-55	RADIOLOGY-DIAGNOSTIC	41		
49.02 MISC	B	-165	LABORATORY	44		
49.03						
49.04						
49.05						
50 TOTAL (SUM OF LINES 1 THRU 49)		485,553				

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to worksheet A-7

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & HOME OFFICE	264,451	28,116	236,335	9
2	6	ADMINISTRATIVE & GENERAL HOME OFFICE	1,559,271	177,768	1,381,503	
3	10	HOUSEKEEPING ST. VINCENT HEALTH - CHAR	297	297		
4	17	MEDICAL RECORDS & LIBRARY ST. VINCENT HEALTH - CHAR	11,787	11,787		
4.01	41	RADIOLOGY-DIAGNOSTIC ST. VINCENT HEALTH - CHAR	22,548	22,548		
4.02	44	LABORATORY ST. VINCENT HEALTH - CHAR	6,792	6,792		
4.03	5	EMPLOYEE BENEFITS ST. VINCENT HEALTH - CHAR	108,963	108,963		
4.04	63 50	RURAL HEALTH CLINIC ST. VINCENT HEALTH - CHAR	154,376	154,376		
4.05	6	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHAR	700,386	700,386		
4.06	8	OPERATION OF PLANT ST. VINCENT HEALTH - CHAR	112,547	112,547		
4.11	6	ADMINISTRATIVE & GENERAL ST. VINCENT HOSPITAL - IN	130,888	130,888		
4.12	3	NEW CAP REL COSTS-BLDG & ASCENSION - INTEREST	203,342	217,047	-13,705	9
4.13	4	NEW CAP REL COSTS-MVBLE E ASCENSION - INTEREST	232,352	248,012	-15,660	9
4.14	6	ADMINISTRATIVE & GENERAL ASCENSION - INTEREST	34,258	36,567	-2,309	
4.15	5	EMPLOYEE BENEFITS ASCENSION - PENSION	350,860	350,860		
4.16	6	ADMINISTRATIVE & GENERAL ASCENSION - CHARGEBACK	128,117	128,117		
4.17	6	ADMINISTRATIVE & GENERAL ASCENSION - MAINTENANCE	245,747	245,337	410	
4.18	5	EMPLOYEE BENEFITS SELF INSURANCE	1,824,159	1,575,406	248,753	
4.19						
5		TOTALS	5,960,253	4,255,814	1,704,439	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	G	100.00	ST. VINCENT HEALTH	100.00	ADMINISTRATION
2	B	100.00	ASCENSION	100.00	ADMINISTRATION
3	B	100.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL
4		0.00		0.00	
5		0.00		0.00	

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

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	255
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.29
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	2703.10	849.50		
10	AHSEA (SEE INSTRUCTIONS)	66.07	66.07		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.04	33.04	33.04	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	178,594
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	56,126
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	234,720
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	234,720

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	234,720

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	8,425
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	8,425
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	1,094
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	9,519
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	9,519
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	

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

PHYSICAL THERAPY

- 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)
- 38 SUBTOTAL (SUM OF LINES 36 AND 37)
- 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)
- 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
- 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
- 42 SUBTOTAL (SUM OF LINES 40 AND 41)
- 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)
- TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
- 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)
- 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
- 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	234,720
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	9,519
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	244,239
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	311,241
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	67,002

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	311,241
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	311,241
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	67,002
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR ST. VINCENT JENNINGS HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
REASONABLE COST DETERMINATION FOR THERAPY I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
SERVICES FURNISHED BY OUTSIDE SUPPLIERS I 15-1303 I FROM 7/ 1/2006 I WORKSHEET A-8-4
ON OR AFTER APRIL 10, 1998 I I TO 6/30/2007 I PARTS I - VII

PHYSICAL THERAPY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 67,002
69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE
WITH LINE 65)

PART I - GENERAL INFORMATION

- 1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)
(SEE INSTRUCTIONS)
- 2 LINE 1 MULTIPLIED BY 15 HOURS PER WEEK
- 3 NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE
(SEE INSTRUCTIONS)
- 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE
(SEE INSTRUCTIONS)
- 5 NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)
- 6 NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S))
(SEE INSTRUCTIONS)
- 7 STANDARD TRAVEL EXPENSE RATE 4.29
- 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED		396.00	7.00		
10 AHSEA (SEE INSTRUCTIONS)		62.63	62.63		
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.32	31.32	31.32		
12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01 NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

- 14 SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)
- 15 THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10) 24,801
- 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10) 438
- 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS) 25,239
- 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)
- 19 TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)
- 20 TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS) 25,239

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

- 21 WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES
(SEE INSTRUCTIONS)
- 22 WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES
(SEE INSTRUCTIONS)
- 23 TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS) 25,239

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

- STANDARD TRAVEL ALLOWANCE
- 24 THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)
 - 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
 - 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)
 - 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)
 - 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)
- OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE
- 29 THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
 - 30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
 - 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 - 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 - 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)
 - 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)
 - 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

- STANDARD TRAVEL EXPENSE
- 36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)

OCCUPATIONAL THERAPY

37 ASSISTANTS (LINE 6 TIMES COLUMN 3,
 LINE 11)
 38 SUBTOTAL (SUM OF LINES 36 AND 37)
 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF
 LINES 5 AND 6)
 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES
 COLUMN 2, LINE 10)
 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3,
 LINE 10)
 42 SUBTOTAL (SUM OF LINES 40 AND 41)
 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF
 COLUMNS 1-3, LINE 13)
 TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES;
 COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 38 AND 39 -
 SEE INSTRUCTIONS)
 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL
 EXPENSE (SUM OF LINES 39 AND 42 -
 SEE INSTRUCTIONS)
 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL
 EXPENSE (SUM OF LINES 42 AND 43 -
 SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 25,239
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM
 PART III, LINE 33, 34, OR 35)
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES
 (FROM PART IV, LINES 44, 45, OR 46)
 60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)
 61 EQUIPMENT COST (SEE INSTRUCTIONS)
 62 SUPPLIES (SEE INSTRUCTIONS)
 63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 25,239
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR
 RECORDS) 15,502
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF
 NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES -
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS) 15,502
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS
 LINE MUST AGREE WITH LINE 64) 15,502
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
 TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
 TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
 TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)
 69 EXCESS COST OVER LIMITATION-
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)
 69.01 EXCESS COST OVER LIMITATION-CORF I
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)
 69.31 EXCESS COST OVER LIMITATION- HHA I
 (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
 AS INDICATED IN INSTRUCTIONS)

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR ST. VINCENT JENNINGS HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
REASONABLE COST DETERMINATION FOR THERAPY I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
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ON OR AFTER APRIL 10, 1998 I I TO 6/30/2007 I PARTS I - VII

OCCUPATIONAL THERAPY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

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

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	48
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	720
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	48
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	4.29
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED				
10	AHSEA (SEE INSTRUCTIONS)				
11	30.10	60.20	30.10		
12	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)				
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	3,446
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	3,446
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	3,446

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	60.19
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	43,337
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	43,337

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	1,445
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	1,445
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	206
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	1,651
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	1,651
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

STANDARD TRAVEL EXPENSE		
36	THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)	

SPEECH PATHOLOGY

- 37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)
- 38 SUBTOTAL (SUM OF LINES 36 AND 37)
- 39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)
- 40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)
- 41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)
- 42 SUBTOTAL (SUM OF LINES 40 AND 41)
- 43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)
- TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE
- 44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)
- 45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)
- 46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO) (ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	43,337
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	1,651
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	44,988
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	3,278
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	3,278
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	3,278
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION - (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION - CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION - HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR ST. VINCENT JENNINGS HOSPITAL IN LIEU OF FORM CMS-2552-96(12/1999)
REASONABLE COST DETERMINATION FOR THERAPY I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
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ON OR AFTER APRIL 10, 1998 I I TO 6/30/2007 I PARTS I - VII

SPEECH PATHOLOGY

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69) (THIS LINE MUST AGREE
WITH LINE 65)

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR	VALUE
3	NEW CAP REL COSTS-BLDG & FIXT	7	SQUARE	FEET
3.01	NEW CAP REL COSTS-BLDG & FIXT	45	SQUARE	FEET
4	NEW CAP REL COSTS-MVBLE EQUIP	47	SQUARE	FEET
4.01	NEW CAP REL COSTS-MVBLE EQUIP	46	SQUARE	FEET
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST
7	MAINTENANCE & REPAIRS	6	SQUARE	FEET
8	OPERATION OF PLANT	7	SQUARE	FEET
9	LAUNDRY & LINEN SERVICE	8	ITEMIZED	BILLS
10	HOUSEKEEPING	9	HOURS OF	SERVICE
11	DIETARY	10	MEALS	SERVED
12	CAFETERIA	11	HOURS	
13	MAINTENANCE OF PERSONNEL	12	NUMBER	HOUSED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.
16	PHARMACY	15	COSTED	REQUIS.
17	MEDICAL RECORDS & LIBRARY	16	GROSS	REVENUE
18	SOCIAL SERVICE	17	TIME	SPENT
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME
21	NURSING SCHOOL	19	ASSIGNED	TIME
22	I&R SERVICES-SALARY & FRINGES APPRVD	20	ASSIGNED	TIME
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED	TIME
24	PARAMED ED PRGM	22	ASSIGNED	TIME

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	EMPLOYEE BENE	SUBTOTAL	ADMINISTRATIV	MAINTENANCE &	OPERATION OF	LAUNDRY & LIN	HOUSEKEEPING
	FITS		E & GENERAL	REPAIRS	PLANT	EN SERVICE	
	5	5a.00	6	7	8	9	10
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
003 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS	3,076,659						
006 ADMINISTRATIVE & GENERAL	193,324	3,639,136	3,639,136				
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT	41,582	949,576	182,514		1,132,090		
009 LAUNDRY & LINEN SERVICE		93,126	17,899		1,470	112,495	
010 HOUSEKEEPING	90,179	504,626	96,992		27,766	326	629,710
011 DIETARY	12,114	60,437	11,616		13,690		21,964
012 CAFETERIA	23,449	164,913	31,697		28,211		
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	37,691	167,096	32,117		3,210		
015 CENTRAL SERVICES & SUPPLY	24,993	139,733	26,858		22,507		
016 PHARMACY	40,760	624,314	119,997		12,665		4,903
017 MEDICAL RECORDS & LIBRARY	166,120	1,199,190	230,492		129,414		11,767
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	302,086	1,386,308	266,457		126,920	17,936	160,809
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER							
034 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
036 01 ICF/MR							
037 OTHER LONG TERM CARE							
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	261,755	963,583	185,206		100,855	42,279	86,289
040 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC	261,118	1,942,944	373,445		81,732	15,664	75,306
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	199,277	1,594,363	306,446		30,241		37,653
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	10,723	62,595	12,031				
050 PHYSICAL THERAPY	46,163	511,997	98,409		32,716	9,085	11,767
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY		3,278	630				
053 ELECTROCARDIOLOGY	3,253	17,939	3,448		3,848		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED		812,931	156,250				
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY	234,063	1,794,273	344,870		81,636	22,503	65,893
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	846,777	4,274,582	821,610		269,056	4,702	97,271
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	2,795,427	20,906,940	3,318,984		965,937	112,495	573,622
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP		7,453	1,433		7,000		
098 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC		16,287	3,130		15,295		
099 NONPAID WORKERS							
100 WIC	33,122	180,330	34,661				15,689
100 01 TOBACCO/CHILD GRANT							
100 02 CLINIC	248,110	1,461,600	280,928		143,858		40,399
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	3,076,659	22,572,610	3,639,136		1,132,090	112,495	629,710

	DIETARY	CAFETERIA	MAINTENANCE O NURSING ADMIN	CENTRAL SERVI PHARMACY	MEDICAL RECOR
COST CENTER DESCRIPTION	11	12	13	15	17
001 GENERAL SERVICE COST CNTR					
002 OLD CAP REL COSTS-BLDG &					
003 OLD CAP REL COSTS-MVBLE E					
003 01 NEW CAP REL COSTS-BLDG &					
004 NEW CAP REL COSTS-MVBLE E					
004 01 NEW CAP REL COSTS-MVBLE E					
005 EMPLOYEE BENEFITS					
006 ADMINISTRATIVE & GENERAL					
007 MAINTENANCE & REPAIRS					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY	107,707				
012 CAFETERIA		224,821			
013 MAINTENANCE OF PERSONNEL					
014 NURSING ADMINISTRATION		1,191		203,614	
015 CENTRAL SERVICES & SUPPLY		3,350		192,448	
016 PHARMACY		2,518		100	764,497
017 MEDICAL RECORDS & LIBRARY		35,687		755	1,607,305
018 SOCIAL SERVICE					
020 NONPHYSICIAN ANESTHETISTS					
021 NURSING SCHOOL					
022 I&R SERVICES-SALARY & FRI					
023 I&R SERVICES-OTHER PRGM C					
024 PARAMED ED PRGM					
025 INPAT ROUTINE SRVC CNTRS					
026 ADULTS & PEDIATRICS	107,707	26,225		121,787	9,582
027 INTENSIVE CARE UNIT					
028 CORONARY CARE UNIT					
029 BURN INTENSIVE CARE UNIT					
031 SURGICAL INTENSIVE CARE U					
033 SUBPROVIDER					
034 NURSERY					
035 SKILLED NURSING FACILITY					
036 01 NURSING FACILITY					
037 ICF/MR					
038 OTHER LONG TERM CARE					
039 ANCILLARY SRVC COST CNTRS					
040 OPERATING ROOM		15,907		39,962	363
041 RECOVERY ROOM					
042 DELIVERY ROOM & LABOR ROO					
043 ANESTHESIOLOGY					
044 RADIOLOGY-DIAGNOSTIC		20,866		13,321	7,048
045 RADIOLOGY-THERAPEUTIC					
046 RADIOISOTOPE					
047 LABORATORY		19,602			2,614
048 PBP CLINICAL LAB SERVICES					
049 WHOLE BLOOD & PACKED RED					
050 BLOOD STORING, PROCESSING					
051 INTRAVENOUS THERAPY					
052 RESPIRATORY THERAPY					1,332
053 PHYSICAL THERAPY		3,822			3,156
054 OCCUPATIONAL THERAPY					
055 SPEECH PATHOLOGY					
056 ELECTROCARDIOLOGY					10
057 ELECTROENCEPHALOGRAPHY					
058 MEDICAL SUPPLIES CHARGED					147,086
059 DRUGS CHARGED TO PATIENTS					
060 RENAL DIALYSIS					764,497
061 ASC (NON-DISTINCT PART)					
062 OUTPAT SERVICE COST CNTRS					
063 CLINIC					
064 EMERGENCY		20,090		28,544	12,879
065 OBSERVATION BEDS (NON-DIS					
066 OTHER OUTPATIENT SERVICE					
067 50 RURAL HEALTH CLINIC		61,459			5,386
068 OTHER REIMBURS COST CNTRS					
069 HOME PROGRAM DIALYSIS					
070 AMBULANCE SERVICES					
071 DURABLE MEDICAL EQUIP-REN					
072 DURABLE MEDICAL EQUIP-SOL					
073 CORF					
074 I&R SERVICES-NOT APPRVD P					
075 HOME HEALTH AGENCY					
076 LUNG ACQUISITION					
077 SPEC PURPOSE COST CENTERS					
078 KIDNEY ACQUISITION					
079 LIVER ACQUISITION					
080 HEART ACQUISITION					
081 01 PANCREAS ACQUISITION					
082 AMBULATORY SURGICAL CENTE					
083 HOSPICE					
084 SUBTOTALS	107,707	210,717		203,614	190,311
085 NONREIMBURS COST CENTERS					
086 GIFT, FLOWER, COFFEE SHOP					
087 RESEARCH					
088 PHYSICIANS' PRIVATE OFFIC					
089 NONPAID WORKERS					
090 WIC		4,339			384
091 01 TOBACCO/CHILD GRANT					
092 02 CLINIC		9,765			1,753
093 CROSS FOOT ADJUSTMENT					
094 NEGATIVE COST CENTER					
095 TOTAL	107,707	224,821		203,614	192,448
096					
097					
098					
099					
100					
101					
102					
103					
TOTAL	107,707	224,821		203,614	192,448
					764,497
					1,607,305

COST CENTER DESCRIPTION	18	20	21	22	23	24	25
GENERAL SERVICE COST CNTR							
001 OLD CAP REL COSTS-BLDG &							
002 OLD CAP REL COSTS-MVBLE E							
003 NEW CAP REL COSTS-BLDG &							
003 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY							
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS							2,279,734
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM							1,695,659
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC							2,986,911
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY							2,306,511
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY							88,917
050 PHYSICAL THERAPY							724,945
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							3,917
053 ELECTROCARDIOLOGY							38,669
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							1,177,041
056 DRUGS CHARGED TO PATIENTS							843,230
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY							2,593,953
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC							5,534,066
OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS							20,273,553
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							15,886
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							34,712
099 NONPAID WORKERS							
100 WIC							235,403
100 01 TOBACCO/CHILD GRANT							
100 02 CLINIC							2,013,056
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL							22,572,610

COST CENTER DESCRIPTION	I&R COST POST STEP-DOWN ADJ 26	TOTAL
	26	27
001 GENERAL SERVICE COST CNTR		
002 OLD CAP REL COSTS-BLDG &		
003 OLD CAP REL COSTS-MVBLE E		
003 01 NEW CAP REL COSTS-BLDG &		
004 NEW CAP REL COSTS-MVBLE E		
004 01 NEW CAP REL COSTS-MVBLE E		
005 EMPLOYEE BENEFITS		
006 ADMINISTRATIVE & GENERAL		
007 MAINTENANCE & REPAIRS		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVICE		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
013 MAINTENANCE OF PERSONNEL		
014 NURSING ADMINISTRATION		
015 CENTRAL SERVICES & SUPPLY		
016 PHARMACY		
017 MEDICAL RECORDS & LIBRARY		
018 SOCIAL SERVICE		
020 NONPHYSICIAN ANESTHETISTS		
021 NURSING SCHOOL		
022 I&R SERVICES-SALARY & FRI		
023 I&R SERVICES-OTHER PRGM C		
024 PARAMED ED PRGM		
025 INPAT ROUTINE SRVC CNTRS		2,279,734
026 ADULTS & PEDIATRICS		
027 INTENSIVE CARE UNIT		
028 CORONARY CARE UNIT		
029 BURN INTENSIVE CARE UNIT		
029 SURGICAL INTENSIVE CARE U		
031 SUBPROVIDER		
033 NURSERY		
034 SKILLED NURSING FACILITY		
035 NURSING FACILITY		
035 01 ICF/MR		
036 OTHER LONG TERM CARE		
037 ANCILLARY SRVC COST CNTRS		1,695,659
038 OPERATING ROOM		
039 RECOVERY ROOM		
039 DELIVERY ROOM & LABOR ROO		
040 ANESTHESIOLOGY		
041 RADIOLOGY-DIAGNOSTIC		2,986,911
042 RADIOLOGY-THERAPEUTIC		
043 RADIOISOTOPE		
044 LABORATORY		2,306,511
045 PBP CLINICAL LAB SERVICES		
046 WHOLE BLOOD & PACKED RED		
047 BLOOD STORING, PROCESSING		
048 INTRAVENOUS THERAPY		
049 RESPIRATORY THERAPY		88,917
050 PHYSICAL THERAPY		724,945
051 OCCUPATIONAL THERAPY		
052 SPEECH PATHOLOGY		3,917
053 ELECTROCARDIOLOGY		38,669
054 ELECTROENCEPHALOGRAPHY		
055 MEDICAL SUPPLIES CHARGED		1,177,041
056 DRUGS CHARGED TO PATIENTS		843,230
057 RENAL DIALYSIS		
058 ASC (NON-DISTINCT PART)		
060 OUTPAT SERVICE COST CNTRS		
061 CLINIC		
061 EMERGENCY		2,593,953
062 OBSERVATION BEDS (NON-DIS		
063 OTHER OUTPATIENT SERVICE		
063 50 RURAL HEALTH CLINIC		5,534,066
063 OTHER REIMBURS COST CNTRS		
064 HOME PROGRAM DIALYSIS		
065 AMBULANCE SERVICES		
066 DURABLE MEDICAL EQUIP-REN		
067 DURABLE MEDICAL EQUIP-SOL		
069 CORF		
070 I&R SERVICES-NOT APPRVD P		
071 HOME HEALTH AGENCY		
082 LUNG ACQUISITION		
082 SPEC PURPOSE COST CENTERS		
083 KIDNEY ACQUISITION		
084 LIVER ACQUISITION		
085 HEART ACQUISITION		
085 01 PANCREAS ACQUISITION		
092 AMBULATORY SURGICAL CENTE		
093 HOSPICE		
095 SUBTOTALS		20,273,553
096 NONREIMBURS COST CENTERS		
097 GIFT, FLOWER, COFFEE SHOP		15,886
097 RESEARCH		
098 PHYSICIANS' PRIVATE OFFIC		34,712
099 NONPAID WORKERS		
100 WIC		235,403
100 01 TOBACCO/CHILD GRANT		
100 02 CLINIC		2,013,056
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 TOTAL		22,572,610

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	DIETARY 11	CAFETERIA 12	MAINTENANCE O F PERSONNEL 13	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY	17,919						
012 CAFETERIA		34,586					
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION		183		5,115			
015 CENTRAL SERVICES & SUPPLY		515			28,163		
016 PHARMACY		387			15	19,912	
017 MEDICAL RECORDS & LIBRARY		5,490			111		167,916
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	17,919	4,034		3,059	1,402		5,851
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		2,447		1,004	53		27,291
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		3,210		335	1,031		47,692
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY		3,016			383		32,972
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY					195		1,354
050 PHYSICAL THERAPY		588			462		5,641
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							1
053 ELECTROCARDIOLOGY					1		1,402
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED					21,525		6,350
056 DRUGS CHARGED TO PATIENTS						19,912	8,226
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY		3,091		717	1,885		23,326
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		9,456			788		
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES							
067 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	17,919	32,417		5,115	27,851	19,912	160,106
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP							
098 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 WIC		667			56		
100 01 TOBACCO/CHILD GRANT							
100 02 CLINIC		1,502			256		7,810
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	17,919	34,586		5,115	28,163	19,912	167,916

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
 I 15-1303 I FROM 7/ 1/2006 I WORKSHEET 8-1
 I I TO 6/30/2007 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C
	OSTS-BLDG &)	OSTS-MVBLE E)	OSTS-BLDG &)	OSTS-BLDG &)	OSTS-MVBLE E)	OSTS-MVBLE E)
	(SQUARE FEET)	(DOLLAR VALUE)	(SQUARE FEET)			
	1	2	3	3.01	4	4.01
001 GENERAL SERVICE COST CNTR						
002 OLD CAP REL COSTS-BLDG &						
003 OLD CAP REL COSTS-MVBLE E						
003 01 NEW CAP REL COSTS-BLDG &			71,117			
004 NEW CAP REL COSTS-MVBLE E					71,117	
004 01 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL			6,181		6,181	
007 MAINTENANCE & REPAIRS						
008 OPERATION OF PLANT			6,387		6,387	
009 LAUNDRY & LINEN SERVICE			76		76	
010 HOUSEKEEPING			1,436		1,436	
011 DIETARY			708		708	
012 CAFETERIA			1,459		1,459	
013 MAINTENANCE OF PERSONNEL						
014 NURSING ADMINISTRATION			166		166	
015 CENTRAL SERVICES & SUPPLY			1,164		1,164	
016 PHARMACY			655		655	
017 MEDICAL RECORDS & LIBRARY			6,693		6,693	
018 SOCIAL SERVICE						
020 NONPHYSICIAN ANESTHETISTS						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY & FRI						
023 I&R SERVICES-OTHER PRGM C						
024 PARAMED ED PRGM						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS			6,564		6,564	
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
028 BURN INTENSIVE CARE UNIT						
029 SURGICAL INTENSIVE CARE U						
031 SUBPROVIDER						
033 NURSERY						
034 SKILLED NURSING FACILITY						
035 NURSING FACILITY						
035 01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST CNTRS						
038 OPERATING ROOM			5,216		5,216	
038 RECOVERY ROOM						
039 DELIVERY ROOM & LABOR ROO						
040 ANESTHESIOLOGY						
041 RADIOLOGY-DIAGNOSTIC			4,227		4,227	
042 RADIOLOGY-THERAPEUTIC						
043 RADIOISOTOPE						
044 LABORATORY			1,564		1,564	
045 PBP CLINICAL LAB SERVICES						
046 WHOLE BLOOD & PACKED RED						
047 BLOOD STORING, PROCESSING						
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY						
050 PHYSICAL THERAPY			1,692		1,692	
051 OCCUPATIONAL THERAPY						
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY			199		199	
054 ELECTROENCEPHALOGRAPHY						
055 MEDICAL SUPPLIES CHARGED						
056 DRUGS CHARGED TO PATIENTS						
057 RENAL DIALYSIS						
058 ASC (NON-DISTINCT PART)						
060 OUTPAT SERVICE COST CNTRS						
061 CLINIC						
061 EMERGENCY			4,222		4,222	
062 OBSERVATION BEDS (NON-DIS						
063 OTHER OUTPATIENT SERVICE						
063 50 RURAL HEALTH CLINIC			13,915		13,915	
064 OTHER REIMBURS COST CNTRS						
064 HOME PROGRAM DIALYSIS						
065 AMBULANCE SERVICES						
066 DURABLE MEDICAL EQUIP-REN						
067 DURABLE MEDICAL EQUIP-SOL						
069 CORF						
070 I&R SERVICES-NOT APPRVD P						
071 HOME HEALTH AGENCY						
082 LUNG ACQUISITION						
083 SPEC PURPOSE COST CENTERS						
083 KIDNEY ACQUISITION						
084 LIVER ACQUISITION						
085 HEART ACQUISITION						
085 01 PANCREAS ACQUISITION						
092 AMBULATORY SURGICAL CENTE						
093 HOSPICE						
095 SUBTOTALS			62,524		62,524	
096 NONREIMBURS COST CENTERS						
097 GIFT, FLOWER, COFFEE SHOP			362		362	
097 RESEARCH						
098 PHYSICIANS' PRIVATE OFFIC			791		791	
099 NONPAID WORKERS						
100 WIC						
100 01 TOBACCO/CHILD GRANT						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-BLDG &	OSTS-MVBLE E	OSTS-MVBLE E
	(SQUARE FEET)	(DOLLAR VALUE)	(SQUARE FEET)			
	1	2	3	3.01	4	4.01
NONREIMBURS COST CENTERS						
100 02 CLINIC			7,440		7,440	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED			818,126		646,206	
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER			11.503944		9.086519	
(WRKSHT B, PT I)						
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED						
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER						
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	EMPLOYEE BENEFITS		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		(GROSS SALARIES)	RECONCILIATION	(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(ITEMIZED) ILLS	(HOURS OF SERVICE)
		5	6a.00	6	7	8	9	10
100	02 NONREIMBURS COST CENTERS							
101	CLINIC	807,671		1,461,600		7,440		206
102	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	3,076,659		3,639,136		1,132,090	112,495	629,710
104	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER	.307192		.192206		19.335770	1.228648	196.110246
105	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED							
106	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
107	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED			127,270		137,895	2,370	36,349
108	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER			.006722		2.355207	.025885	11.320149
	(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	MAINTENANCE O F PERSONNEL	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDICAL RECOR DS & LIBRARY
	(MEALS SERVED)	(HOURS)	(NUMBER HOUSED)	(DIRECT NRSING HRS)	(COSTED REQUIS.)	(COSTED REQUIS.)	(GROSS REVENUE)
NONREIMBURS COST CENTERS	11	12	13	14	15	16	17
100 02 CLINIC		17,059			7,678		1,856,423
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	107,707	224,821		203,614	192,448	764,497	1,607,305
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	1,077.070000	.572397		1,902.934579	.228266	7,644.970000	.040267
(WRKSHT B, PT I)							
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED	17,919	34,586		5,115	28,163	19,912	167,916
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER	179.190000	.088056		47.803738	.033405	199.120000	.004207
(WRKSHT B, PT III)							

COST CENTER DESCRIPTION	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	NURSING SCHOO L	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM
	(TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)
	18	20	21	22	23	24
001	GENERAL SERVICE COST CNTR					
002	OLD CAP REL COSTS-BLDG &					
003	OLD CAP REL COSTS-MVBLE E					
003	01 NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
004	01 NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
007	MAINTENANCE & REPAIRS					
008	OPERATION OF PLANT					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
013	MAINTENANCE OF PERSONNEL					
014	NURSING ADMINISTRATION					
015	CENTRAL SERVICES & SUPPLY					
016	PHARMACY					
017	MEDICAL RECORDS & LIBRARY					
018	SOCIAL SERVICE					
020	NONPHYSICIAN ANESTHETISTS					
021	NURSING SCHOOL					
022	I&R SERVICES-SALARY & FRI					
023	I&R SERVICES-OTHER PRGM C					
024	PARAMED ED PRGM					
025	INPAT ROUTINE SRVC CNTRS					
026	ADULTS & PEDIATRICS					
027	INTENSIVE CARE UNIT					
028	CORONARY CARE UNIT					
029	BURN INTENSIVE CARE UNIT					
031	SURGICAL INTENSIVE CARE U					
031	SUBPROVIDER					
033	NURSERY					
034	SKILLED NURSING FACILITY					
035	NURSING FACILITY					
035	01 ICF/MR					
036	OTHER LONG TERM CARE					
037	ANCILLARY SRVC COST CNTRS					
038	OPERATING ROOM					
039	RECOVERY ROOM					
040	DELIVERY ROOM & LABOR ROO					
041	ANESTHESIOLOGY					
042	RADIOLOGY-DIAGNOSTIC					
043	RADIOLOGY-THERAPEUTIC					
044	RADIOISOTOPE					
045	LABORATORY					
046	PBP CLINICAL LAB SERVICES					
047	WHOLE BLOOD & PACKED RED					
048	BLOOD STORING, PROCESSING					
049	INTRAVENOUS THERAPY					
050	RESPIRATORY THERAPY					
051	PHYSICAL THERAPY					
052	OCCUPATIONAL THERAPY					
053	SPEECH PATHOLOGY					
054	ELECTROCARDIOLOGY					
055	ELECTROENCEPHALOGRAPHY					
056	MEDICAL SUPPLIES CHARGED					
057	DRUGS CHARGED TO PATIENTS					
058	RENAL DIALYSIS					
060	ASC (NON-DISTINCT PART)					
061	OUTPAT SERVICE COST CNTRS					
062	CLINIC					
063	EMERGENCY					
063	050 OBSERVATION BEDS (NON-DIS					
064	OTHER OUTPATIENT SERVICE					
064	050 RURAL HEALTH CLINIC					
065	OTHER REIMBURS COST CNTRS					
066	HOME PROGRAM DIALYSIS					
067	AMBULANCE SERVICES					
068	DURABLE MEDICAL EQUIP-REN					
069	DURABLE MEDICAL EQUIP-SOL					
070	CORF					
071	I&R SERVICES-NOT APPRVD P					
072	HOME HEALTH AGENCY					
073	LUNG ACQUISITION					
074	SPEC PURPOSE COST CENTERS					
075	KIDNEY ACQUISITION					
076	LIVER ACQUISITION					
077	HEART ACQUISITION					
078	01 PANCREAS ACQUISITION					
079	AMBULATORY SURGICAL CENTE					
080	HOSPICE					
081	SUBTOTALS					
082	NONREIMBURS COST CENTERS					
083	GIFT, FLOWER, COFFEE SHOP					
084	RESEARCH					
085	PHYSICIANS' PRIVATE OFFIC					
086	NONPAID WORKERS					
087	WIC					
088	01 TOBACCO/CHILD GRANT					

COST CENTER DESCRIPTION	SOCIAL SERVIC E	NONPHYSICIAN ANESTHETISTS	NURSING SCHOO L	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PR GM
	(TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)
	18	20	21	22	23	24
NONREIMBURS COST CENTERS						
100 02 CLINIC						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (PER WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)						
105 COST TO BE ALLOCATED (PER WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED (PER WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)						

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27	THERAPY ADJUSTMENT	TOTAL COSTS	RCE DISALLOWANCE	TOTAL COSTS
		1	2	3	4	5
25	INPAT ROUTINE SRVC CNTRS					
26	ADULTS & PEDIATRICS	2,279,734		2,279,734		
27	INTENSIVE CARE UNIT					
28	CORONARY CARE UNIT					
29	BURN INTENSIVE CARE UNIT					
31	SURGICAL INTENSIVE CARE U					
33	SUBPROVIDER					
34	NURSERY					
35	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE					
37	ANCILLARY SRVC COST CNTRS					
38	OPERATING ROOM	1,695,659		1,695,659		
39	RECOVERY ROOM					
40	DELIVERY ROOM & LABOR ROO					
41	ANESTHESIOLOGY					
42	RADIOLOGY-DIAGNOSTIC	2,986,911		2,986,911		
43	RADIOLOGY-THERAPEUTIC					
44	RADIOISOTOPE					
45	LABORATORY	2,306,511		2,306,511		
46	PBP CLINICAL LAB SERVICES					
47	WHOLE BLOOD & PACKED RED					
48	BLOOD STORING, PROCESSING					
49	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	88,917		88,917		
50	PHYSICAL THERAPY	724,945		724,945		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	3,917		3,917		
53	ELECTROCARDIOLOGY	38,669		38,669		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,177,041		1,177,041		
56	DRUGS CHARGED TO PATIENTS	843,230		843,230		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
60	OUTPAT SERVICE COST CNTRS					
61	CLINIC					
61	EMERGENCY	2,593,953		2,593,953		
62	OBSERVATION BEDS (NON-DIS	397,728		397,728		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	5,534,066		5,534,066		
64	OTHER REIMBURS COST CNTRS					
65	HOME PROGRAM DIALYSIS					
66	AMBULANCE SERVICES					
67	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	20,671,281		20,671,281		
102	LESS OBSERVATION BEDS	397,728		397,728		
103	TOTAL	20,273,553		20,273,553		

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,069,479		1,069,479			
26	INTENSIVE CARE UNIT						
27	CORONARY CARE UNIT						
28	BURN INTENSIVE CARE UNIT						
29	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
33	NURSERY						
34	SKILLED NURSING FACILITY						
35	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE						
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	216,961	6,270,120	6,487,081	.261390	.261390	
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	483,550	10,855,428	11,338,978	.263420	.263420	
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	504,909	7,332,576	7,837,485	.294292	.294292	
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY	237,504	84,329	321,833	.276283	.276283	
50	RESPIRATORY THERAPY	101,626	1,239,253	1,340,879	.540649	.540649	
51	PHYSICAL THERAPY						
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	220		220	17.804545	17.804545	
54	ELECTROCARDIOLOGY	54,101	279,271	333,372	.115994	.115994	
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	365,100	1,144,180	1,509,280	.779869	.779869	
57	DRUGS CHARGED TO PATIENTS	866,147	1,089,131	1,955,278	.431258	.431258	
58	RENAL DIALYSIS						
60	ASC (NON-DISTINCT PART)						
61	OUTPAT SERVICE COST CNTRS						
62	CLINIC						
63	EMERGENCY	133,779	5,410,848	5,544,627	.467832	.467832	
64	OBSERVATION BEDS (NON-DIS		321,304	321,304	1.237856	1.237856	
65	OTHER OUTPATIENT SERVICE						
66	50 RURAL HEALTH CLINIC		5,072,975	5,072,975	1.090892	1.090892	
67	OTHER REIMBURS COST CNTRS						
101	HOME PROGRAM DIALYSIS						
102	AMBULANCE SERVICES						
103	DURABLE MEDICAL EQUIP-REN						
104	DURABLE MEDICAL EQUIP-SOL						
105	SUBTOTAL	4,033,376	39,099,415	43,132,791			
106	LESS OBSERVATION BEDS						
107	TOTAL	4,033,376	39,099,415	43,132,791			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,279,734		2,279,734		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,695,659		1,695,659		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC	2,986,911		2,986,911		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,306,511		2,306,511		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	88,917		88,917		
50	PHYSICAL THERAPY	724,945		724,945		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	3,917		3,917		
53	ELECTROCARDIOLOGY	38,669		38,669		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,177,041		1,177,041		
56	DRUGS CHARGED TO PATIENTS	843,230		843,230		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,593,953		2,593,953		
62	OBSERVATION BEDS (NON-DIS	397,728		397,728		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	5,534,066		5,534,066		
64	OTHER REIMBURS COST CNTRS					
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES					
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	20,671,281		20,671,281		
102	LESS OBSERVATION BEDS	397,728		397,728		
103	TOTAL	20,273,553		20,273,553		

COMPUTATION OF RATIO OF COSTS TO CHARGES
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	1,069,479		1,069,479			
27	INTENSIVE CARE UNIT						
28	CORONARY CARE UNIT						
29	BURN INTENSIVE CARE UNIT						
30	SURGICAL INTENSIVE CARE U						
31	SUBPROVIDER						
32	NURSERY						
33	SKILLED NURSING FACILITY						
34	NURSING FACILITY						
35	01 ICF/MR						
36	OTHER LONG TERM CARE						
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	216,961	6,270,120	6,487,081	.261390	.261390	
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	483,550	10,855,428	11,338,978	.263420	.263420	
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	504,909	7,332,576	7,837,485	.294292	.294292	
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	237,504	84,329	321,833	.276283	.276283	
51	PHYSICAL THERAPY	101,626	1,239,253	1,340,879	.540649	.540649	
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	220		220	17.804545	17.804545	
54	ELECTROCARDIOLOGY	54,101	279,271	333,372	.115994	.115994	
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	365,100	1,144,180	1,509,280	.779869	.779869	
57	DRUGS CHARGED TO PATIENTS	866,147	1,089,131	1,955,278	.431258	.431258	
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	133,779	5,410,848	5,544,627	.467832	.467832	
63	OBSERVATION BEDS (NON-DIS		321,304	321,304	1.237856	1.237856	
64	OTHER OUTPATIENT SERVICE						
65	50 RURAL HEALTH CLINIC		5,072,975	5,072,975	1.090892	1.090892	
66	OTHER REIMBURS COST CNTRS						
67	HOME PROGRAM DIALYSIS						
68	AMBULANCE SERVICES						
69	DURABLE MEDICAL EQUIP-REN						
70	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	4,033,376	39,099,415	43,132,791			
102	LESS OBSERVATION BEDS						
103	TOTAL	4,033,376	39,099,415	43,132,791			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	1,695,659	162,829	1,532,830			1,695,659
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	2,986,911	166,996	2,819,915			2,986,911
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,306,511	85,148	2,221,363			2,306,511
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	88,917	1,970	86,947			88,917
51	PHYSICAL THERAPY	724,945	49,827	675,118			724,945
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	3,917	23	3,894			3,917
54	ELECTROCARDIOLOGY	38,669	6,090	32,579			38,669
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	1,177,041	33,340	1,143,701			1,177,041
57	DRUGS CHARGED TO PATIENTS	843,230	28,138	815,092			843,230
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,593,953	142,235	2,451,718			2,593,953
63	OBSERVATION BEDS (NON-DIS	397,728		397,728			397,728
64	OTHER OUTPATIENT SERVICE						
65	50 RURAL HEALTH CLINIC	5,534,066	363,979	5,170,087			5,534,066
66	OTHER REIMBURS COST CNTRS						
67	HOME PROGRAM DIALYSIS						
68	AMBULANCE SERVICES						
69	DURABLE MEDICAL EQUIP-REN						
70	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	18,391,547	1,040,575	17,350,972			18,391,547
102	LESS OBSERVATION BEDS	397,728		397,728			397,728
103	TOTAL	17,993,819	1,040,575	16,953,244			17,993,819

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	6,487,081	.261390	.261390
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	11,338,978	.263420	.263420
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	7,837,485	.294292	.294292
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	321,833	.276283	.276283
51	PHYSICAL THERAPY	1,340,879	.540649	.540649
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	220	17.804545	17.804545
54	ELECTROCARDIOLOGY	333,372	.115994	.115994
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	1,509,280	.779869	.779869
57	DRUGS CHARGED TO PATIENTS	1,955,278	.431258	.431258
58	RENAL DIALYSIS			
59	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
62	EMERGENCY	5,544,627	.467832	.467832
63	OBSERVATION BEDS (NON-DIS	321,304	1.237856	1.237856
64	OTHER OUTPATIENT SERVICE			
65	RURAL HEALTH CLINIC	5,072,975	1.090892	1.090892
66	OTHER REIMBURS COST CNTRS			
67	HOME PROGRAM DIALYSIS			
68	AMBULANCE SERVICES			
69	DURABLE MEDICAL EQUIP-REN			
70	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	42,063,312		
102	LESS OBSERVATION BEDS	321,304		
103	TOTAL	41,742,008		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	1,695,659	162,829	1,532,830			1,695,659
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	2,986,911	166,996	2,819,915			2,986,911
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,306,511	85,148	2,221,363			2,306,511
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	88,917	1,970	86,947			88,917
51	PHYSICAL THERAPY	724,945	49,827	675,118			724,945
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	3,917	23	3,894			3,917
54	ELECTROCARDIOLOGY	38,669	6,090	32,579			38,669
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	1,177,041	33,340	1,143,701			1,177,041
57	DRUGS CHARGED TO PATIENTS	843,230	28,138	815,092			843,230
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,593,953	142,235	2,451,718			2,593,953
63	OBSERVATION BEDS (NON-DIS	397,728		397,728			397,728
64	OTHER OUTPATIENT SERVICE						
65	50 RURAL HEALTH CLINIC	5,534,066	363,979	5,170,087			5,534,066
66	OTHER REIMBURS COST CNTRS						
67	HOME PROGRAM DIALYSIS						
68	AMBULANCE SERVICES						
69	DURABLE MEDICAL EQUIP-REN						
70	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	18,391,547	1,040,575	17,350,972			18,391,547
102	LESS OBSERVATION BEDS	397,728		397,728			397,728
103	TOTAL	17,993,819	1,040,575	16,953,244			17,993,819

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	6,487,081	.261390	.261390
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	11,338,978	.263420	.263420
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	7,837,485	.294292	.294292
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	321,833	.276283	.276283
51	PHYSICAL THERAPY	1,340,879	.540649	.540649
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	220	17.804545	17.804545
54	ELECTROCARDIOLOGY	333,372	.115994	.115994
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	1,509,280	.779869	.779869
57	DRUGS CHARGED TO PATIENTS	1,955,278	.431258	.431258
58	RENAL DIALYSIS			
59	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
62	EMERGENCY	5,544,627	.467832	.467832
63	OBSERVATION BEDS (NON-DIS	321,304	1.237856	1.237856
64	OTHER OUTPATIENT SERVICE			
65	RURAL HEALTH CLINIC	5,072,975	1.090892	1.090892
66	OTHER REIMBURS COST CNTRS			
67	HOME PROGRAM DIALYSIS			
68	AMBULANCE SERVICES			
69	DURABLE MEDICAL EQUIP-REN			
70	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	42,063,312		
102	LESS OBSERVATION BEDS	321,304		
103	TOTAL	41,742,008		

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.261390		.261390		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.263420		.263420		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.294292		.294292		
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY	.276283		.276283		
50 PHYSICAL THERAPY	.540649		.540649		
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY	17.804545		17.804545		
53 ELECTROCARDIOLOGY	.115994		.115994		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.779869		.779869		
56 DRUGS CHARGED TO PATIENTS	.431258		.431258		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY	.467832		.467832		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.237856		1.237856		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		2,532,910			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		2,703,715			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		2,546,361			
45 PBP CLINICAL LAB SERVICES--PRGM ONLY					
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY					
49 RESPIRATORY THERAPY		26,532			
50 PHYSICAL THERAPY		348,218			
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY		228,608			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		393,779			
56 DRUGS CHARGED TO PATIENTS		375,383			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
62 EMERGENCY		1,286,902			
63 OBSERVATION BEDS (NON-DISTINCT PART)		134,035			
63 50 OTHER OUTPATIENT SERVICE COST CENTER					
64 RURAL HEALTH CLINIC					
65 OTHER REIMBURS COST CNTRS					
66 HOME PROGRAM DIALYSIS					
67 AMBULANCE SERVICES					
101 DURABLE MEDICAL EQUIP-RENTED					
102 DURABLE MEDICAL EQUIP-SOLD					
103 SUBTOTAL		10,576,443			
104 CRNA CHARGES					
LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
NET CHARGES		10,576,443			

(A) WORKSHEET A LINE NUMBERS
 (1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B		HOSPITAL		
		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center	Description	9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	662,077		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	712,213		
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	749,374		
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	7,330		
50	PHYSICAL THERAPY	188,264		
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	26,517		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	307,096		
56	DRUGS CHARGED TO PATIENTS	161,887		
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	602,054		
62	OBSERVATION BEDS (NON-DISTINCT PART)	165,916		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	SUBTOTAL	3,582,728		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	3,582,728		

(A) WORKSHEET A LINE NUMBERS
 (L) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.431258
2	PROGRAM VACCINE CHARGES		124
3	PROGRAM COSTS		53

TITLE XVIII PART A HOSPITAL OTHER
 PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 958.37
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 801,197
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 801,197

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT					
HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					494,061
					1,295,258

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST 309,554
 REPORTING PERIOD (SEE INSTRUCTIONS)
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST 309,554
 REPORTING PERIOD (SEE INSTRUCTIONS)
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 619,108
 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE
 COST REPORTING PERIOD
 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE
 COST REPORTING PERIOD
 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	415
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	958.38
85	OBSERVATION BED COST	397,728

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					121,232

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 121,232

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 45
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	415
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS		541,179	
27	INTENSIVE CARE UNIT			
28	CORONARY CARE UNIT			
29	BURN INTENSIVE CARE UNIT			
31	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	.261390	43,845	11,461
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROOM			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	.263420	193,478	50,966
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	.294292	251,648	74,058
46	PBP CLINICAL LAB SERVICES-PRGM ONLY			
47	WHOLE BLOOD & PACKED RED BLOOD CELLS			
48	BLOOD STORING, PROCESSING & TRANS.			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	.276283	112,180	30,993
51	PHYSICAL THERAPY	.540649	27,065	14,633
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	17.804545		
54	ELECTROCARDIOLOGY	.115994	43,199	5,011
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	.779869	165,956	129,424
57	DRUGS CHARGED TO PATIENTS	.431258	402,994	173,794
58	RENAL DIALYSIS			
60	ASC (NON-DISTINCT PART)			
61	OUTPAT SERVICE COST CNTRS			
62	CLINIC			
63	EMERGENCY	.467832	7,953	3,721
64	OBSERVATION BEDS (NON-DISTINCT PART)	1.237856		
65	OTHER OUTPATIENT SERVICE COST CENTER			
66	50 RURAL HEALTH CLINIC			
67	OTHER REIMBURS COST CNTRS			
68	HOME PROGRAM DIALYSIS			
69	AMBULANCE SERVICES			
70	DURABLE MEDICAL EQUIP-RENTED			
71	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		1,248,318	494,061
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,248,318	

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS			
27	INTENSIVE CARE UNIT			
28	CORONARY CARE UNIT			
29	BURN INTENSIVE CARE UNIT			
31	SURGICAL INTENSIVE CARE UNIT SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	.261390		
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROOM			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	.263420	26,936	7,095
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	.294292	48,937	14,402
46	PBP CLINICAL LAB SERVICES-PRGM ONLY			
47	WHOLE BLOOD & PACKED RED BLOOD CELLS			
48	BLOOD STORING, PROCESSING & TRANS.			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	.276283	65,294	18,040
51	PHYSICAL THERAPY	.540649	66,284	35,836
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	17.804545	220	3,917
54	ELECTROCARDIOLOGY	.115994	8,420	977
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	.779869	98,964	77,179
57	DRUGS CHARGED TO PATIENTS	.431258	170,037	73,330
58	RENAL DIALYSIS			
60	ASC (NON-DISTINCT PART)			
61	OUTPAT SERVICE COST CNTRS			
62	CLINIC			
63	EMERGENCY	.467832		
64	OBSERVATION BEDS (NON-DISTINCT PART)	1.237856		
65	OTHER OUTPATIENT SERVICE COST CENTER			
66	50 RURAL HEALTH CLINIC			
67	OTHER REIMBURS COST CNTRS			
101	HOME PROGRAM DIALYSIS			
102	AMBULANCE SERVICES			
103	DURABLE MEDICAL EQUIP-RENTED			
	DURABLE MEDICAL EQUIP-SOLD			
	TOTAL		485,092	230,776
	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
	NET CHARGES		485,092	

WKST A LINE NO.	TITLE XIX COST CENTER DESCRIPTION	HOSPITAL RATIO COST TO CHARGES 1	OTHER	
			INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		129,033	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.261390	32,435	8,478
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.263420	55,174	14,534
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.294292	60,285	17,741
45	PBP CLINICAL LAB SERVICES-PRGM ONLY			
46	WHOLE BLOOD & PACKED RED BLOOD CELLS			
47	BLOOD STORING, PROCESSING & TRANS.			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	.276283	39,524	10,920
50	PHYSICAL THERAPY	.540649	2,104	1,138
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	17.804545		
53	ELECTROCARDIOLOGY	.115994	2,482	288
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.779869	2,955	2,305
56	DRUGS CHARGED TO PATIENTS	.431258	76,638	33,051
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.467832	70,061	32,777
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.237856		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC	1.090892		
64	OTHER REIMBURS COST CNTRS			
65	HOME PROGRAM DIALYSIS			
66	AMBULANCE SERVICES			
67	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		341,658	121,232
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		341,658	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,582,781
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.
 1.04 LINE 1.01 TIMES LINE 1.03.
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)
 1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.
 2 INTERNS AND RESIDENTS
 3 ORGAN ACQUISITIONS
 4 COST OF TEACHING PHYSICIANS
 5 TOTAL COST (SEE INSTRUCTIONS) 3,582,781

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES
 6 ANCILLARY SERVICE CHARGES
 7 INTERNS AND RESIDENTS SERVICE CHARGES
 8 ORGAN ACQUISITION CHARGES
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.
 10 TOTAL REASONABLE CHARGES
 CUSTOMARY CHARGES
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS
 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).
 13 RATIO OF LINE 11 TO LINE 12
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,618,609
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 27,865
 18.01 CAH ACTUAL BILLED COINSURANCE 1,607,284
 LINE 17.01 (SEE INSTRUCTIONS)
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,983,460
 20 SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)
 21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS
 22 ESRD DIRECT MEDICAL EDUCATION COSTS
 23 SUBTOTAL 1,983,460
 24 PRIMARY PAYER PAYMENTS 13,404
 25 SUBTOTAL 1,970,056
 REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
 26 COMPOSITE RATE ESRD
 27 BAD DEBTS (SEE INSTRUCTIONS) 571,151
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 571,151
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
 28 SUBTOTAL 2,541,207
 29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.
 30 OTHER ADJUSTMENTS (SPECIFY)
 30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
 31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.
 32 SUBTOTAL 2,541,207
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
 34 INTERIM PAYMENTS 2,643,715
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
 35 BALANCE DUE PROVIDER/PROGRAM -102,508
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) 93,396
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

TITLE XVIII HOSPITAL

DESCRIPTION

INPATIENT-PART A P A R T B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.				
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. (1)				
	ADJUSTMENTS TO PROVIDER	.01			
	ADJUSTMENTS TO PROVIDER	.02			
	ADJUSTMENTS TO PROVIDER	.03			
	ADJUSTMENTS TO PROVIDER	.04			
	ADJUSTMENTS TO PROVIDER	.05			
	ADJUSTMENTS TO PROGRAM	.50	1/15/2007	44,184	1/15/2007 344,705
	ADJUSTMENTS TO PROGRAM	.51			
	ADJUSTMENTS TO PROGRAM	.52			
	ADJUSTMENTS TO PROGRAM	.53			
	ADJUSTMENTS TO PROGRAM	.54			
	ADJUSTMENTS TO PROGRAM	.99			
	SUBTOTAL			-44,184	-344,705
4	TOTAL INTERIM PAYMENTS			986,061	2,643,715
	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. (1)				
	TENTATIVE TO PROVIDER	.01			
	TENTATIVE TO PROVIDER	.02			
	TENTATIVE TO PROVIDER	.03			
	TENTATIVE TO PROGRAM	.50			
	TENTATIVE TO PROGRAM	.51			
	TENTATIVE TO PROGRAM	.52			
	SUBTOTAL	.99		NONE	NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
	SETTLEMENT TO PROVIDER	.01			
	SETTLEMENT TO PROGRAM	.02			
7	TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SWING BED SNF

DESCRIPTION

INPATIENT-PART A P A R T B
 MM/DD/YYYY AMOUNT MM/DD/YYYY AMOUNT
 1 2 3 4

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
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.				
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. (1)				
	ADJUSTMENTS TO PROVIDER	.01			
	ADJUSTMENTS TO PROVIDER	.02			
	ADJUSTMENTS TO PROVIDER	.03			
	ADJUSTMENTS TO PROVIDER	.04			
	ADJUSTMENTS TO PROVIDER	.05			
	ADJUSTMENTS TO PROGRAM	.50	1/15/2007	27,984	
	ADJUSTMENTS TO PROGRAM	.51			
	ADJUSTMENTS TO PROGRAM	.52			
	ADJUSTMENTS TO PROGRAM	.53			
	ADJUSTMENTS TO PROGRAM	.54			
	ADJUSTMENTS TO PROGRAM	.99			
	SUBTOTAL			-27,984	NONE
4	TOTAL INTERIM PAYMENTS			723,504	
	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. (1)				
	TENTATIVE TO PROVIDER	.01			
	TENTATIVE TO PROVIDER	.02			
	TENTATIVE TO PROVIDER	.03			
	TENTATIVE TO PROGRAM	.50			
	TENTATIVE TO PROGRAM	.51			
	TENTATIVE TO PROGRAM	.52			
	TENTATIVE TO PROGRAM	.99			
	SUBTOTAL			NONE	NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
	SETTLEMENT TO PROVIDER	.01			
	SETTLEMENT TO PROGRAM	.02			
7	TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	1,295,258
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,295,258
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,308,211
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	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)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	1,308,211
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	218,611
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,089,600
23	COINSURANCE	238
24	SUBTOTAL	1,089,362
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	46,873
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	46,873
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	1,136,235
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,136,235
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	986,061
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	150,174
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	44,509

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

	TITLE XIX	HOSPITAL	TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES			
3	MEDICAL AND OTHER SERVICES			
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL			
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS			
	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
18	PAYMENT FOR SERVICES ON A CHARGE BASIS			
19	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
20	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
21	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
22	RATIO OF LINE 17 TO LINE 18			
23	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			
24	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
25	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
26	COST OF COVERED SERVICES			
27	PROSPECTIVE PAYMENT AMOUNT			
28	OTHER THAN OUTLIER PAYMENTS			
29	OUTLIER PAYMENTS			
30	PROGRAM CAPITAL PAYMENTS			
31	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
32	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
33	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
34	SUBTOTAL			
35	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
36	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE			
37	XVIII ENTER AMOUNT FROM LINE 30			
38	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
39	EXCESS OF REASONABLE COST			
40	SUBTOTAL			
41	COINSURANCE			
42	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
43	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
44	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
45	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
46	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
47	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
48	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
49	UTILIZATION REVIEW			
50	SUBTOTAL (SEE INSTRUCTIONS)			
51	INPATIENT ROUTINE SERVICE COST			
52	MEDICARE INPATIENT ROUTINE CHARGES			
53	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
54	PAYMENT FOR SERVICES ON A CHARGE BASIS			
55	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
56	FOR PAYMENT OF PART A SERVICES			
57	RATIO OF LINE 43 TO 44			
58	TOTAL CUSTOMARY CHARGES			
59	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
60	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
61	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
62	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
63	OTHER ADJUSTMENTS (SPECIFY)			
64	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
65	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
66	SUBTOTAL			
67	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
68	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
69	TOTAL AMOUNT PAYABLE TO THE PROVIDER			
70	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
71	INTERIM PAYMENTS			
72	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
73	BALANCE DUE PROVIDER/PROGRAM			
74	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			
75	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
I 15-1303 I FROM 7/ 1/2006 I
I I TO 6/30/2007 I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	824,376			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	7,002,538			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,928,328			
7	INVENTORY	143,422			
8	PREPAID EXPENSES	131,364			
9	OTHER CURRENT ASSETS	837,966	71,597		
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,011,338	71,597		
FIXED ASSETS					
12	LAND	127,944			
12.01	LAND IMPROVEMENTS	400,829			
13	LESS ACCUMULATED DEPRECIATION	-323,676			
13.01	BUILDINGS	13,313,334			
14	LESS ACCUMULATED DEPRECIATION	-2,925,711			
14.01	LEASEHOLD IMPROVEMENTS				
15	LESS ACCUMULATED DEPRECIATION				
15.01	FIXED EQUIPMENT	6,596,838			
16	LESS ACCUMULATED DEPRECIATION	-5,080,607			
16.01	AUTOMOBILES AND TRUCKS				
17	LESS ACCUMULATED DEPRECIATION				
17.01	MAJOR MOVABLE EQUIPMENT				
18	LESS ACCUMULATED DEPRECIATION				
18.01	MINOR EQUIPMENT DEPRECIABLE				
19	LESS ACCUMULATED DEPRECIATION				
19.01	MINOR EQUIPMENT-NONDEPRECIABLE				
20	TOTAL FIXED ASSETS	12,108,951			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS		71,597		
27	TOTAL ASSETS	17,120,289	71,597		

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	210,605			
29 SALARIES, WAGES & FEES PAYABLE	973,757			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	199,982			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	2,212,201			
35 OTHER CURRENT LIABILITIES	310,712			
36 TOTAL CURRENT LIABILITIES	3,907,257			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	11,272,059			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	879,540			
42 TOTAL LONG-TERM LIABILITIES	12,151,599			
43 TOTAL LIABILITIES	16,058,856			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	1,061,433			
45 SPECIFIC PURPOSE FUND		71,597		
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	1,061,433	71,597		
52 TOTAL LIABILITIES AND FUND BALANCES	17,120,289	71,597		

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1 FUND BALANCE AT BEGINNING		197,627		38,751
2 OF PERIOD				
3 NET INCOME (LOSS)		1,083,497		
4 TOTAL		1,281,124		38,751
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 RESTRICTED CONTRIBUTIONS	47,806			
7 INVESTMENT INCOME			147	
8 DONATIONS			45,354	
9 GRANT REVENUE			81,373	
10 TOTAL ADDITIONS		47,806		126,874
11 SUBTOTAL		1,328,930		165,625
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEFERRED PENSION COSTS	267,497			
14 TEMP RESTRICTED - RELEASE			46,221	
15 TEMP RESTRICTED - RELEASE			47,807	
16				
17				
18 TOTAL DEDUCTIONS		267,497		94,028
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		1,061,433		71,597

	ENDOWMENT FUND 5	6	PLANT FUND 7	8
1 FUND BALANCE AT BEGINNING				
2 OF PERIOD				
3 NET INCOME (LOSS)				
4 TOTAL				
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
6 RESTRICTED CONTRIBUTIONS				
7 INVESTMENT INCOME				
8 DONATIONS				
9 GRANT REVENUE				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEFERRED PENSION COSTS				
14 TEMP RESTRICTED - RELEASE				
15 TEMP RESTRICTED - RELEASE				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	1,096,036		1,096,036
2 00 SUBPROVIDER			
4 00 SWING BED - SNF	190,048		190,048
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY			
7 00 NURSING FACILITY			
7 01 ICF/MR			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,286,084		1,286,084
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,286,084		1,286,084
17 00 ANCILLARY SERVICES	2,966,576		2,966,576
18 00 OUTPATIENT SERVICES		37,880,698	37,880,698
18 50 RURAL HEALTH CLINIC		5,072,975	5,072,975
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
21 00 CORF			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	4,252,660	42,953,673	47,206,333

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		22,087,057	
ADD (SPECIFY)			
27 00			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		22,087,057	

DESCRIPTION

1	TOTAL PATIENT REVENUES	47,206,333
2	LESS: ALLOWANCES AND DISCOUNTS ON	20,651,120
3	NET PATIENT REVENUES	26,555,213
4	LESS: TOTAL OPERATING EXPENSES	22,087,057
5	NET INCOME FROM SERVICE TO PATIENT	4,468,156
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	35,178
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	23,403
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	9,013
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	51,605
23	GOVERNMENTAL APPROPRIATIONS	
24	UNREALIZED GAINS	2,489
24.01	NET ASSETS RELEASED FROM RESTRICT	46,221
24.02	MISC	31,481
25	TOTAL OTHER INCOME	199,390
26	TOTAL	4,667,546
	OTHER EXPENSES	
27	BAD DEBTS	3,584,049
28		
29		
30	TOTAL OTHER EXPENSES	3,584,049
31	NET INCOME (OR LOSS) FOR THE PERIO	1,083,497

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	718,731	19,622	738,353	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER	1,030,223		1,030,223	
5 VISITING NURSE				
6 OTHER NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS	971,638		971,638	
11 SUBTOTAL (SUM OF LINES 1-9)	2,720,592	19,622	2,740,214	
COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
15 SUBTOTAL (SUM OF LINES 11-13)				
OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES		55,487	55,487	
17 TRANSPORTATION (HEALTH CARE STAFF)		3,764	3,764	
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS		346,133	346,133	
21 ALLOWABLE GME COSTS				
22 SUBTOTAL (SUM OF LINES 15-20)		405,384	405,384	
TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,720,592	425,006	3,145,598	
COSTS OTHER THAN RHC/FQHC SERVICES				
23 PHARMACY				
24 DENTAL				
25 OPTOMETRY				
26 ALL OTHER NONREIMBURSABLE COSTS				
27 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
FACILITY OVERHEAD				
29 FACILITY COSTS		27,381	27,381	
30 ADMINISTRATIVE COSTS				
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		27,381	27,381	
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	2,720,592	452,387	3,172,979	
	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7	
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	738,353		738,353	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER	1,030,223		1,030,223	
5 VISITING NURSE				
6 OTHER NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS	971,638		971,638	
11 SUBTOTAL (SUM OF LINES 1-9)	2,740,214		2,740,214	
COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
15 SUBTOTAL (SUM OF LINES 11-13)				
OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES	55,487		55,487	
17 TRANSPORTATION (HEALTH CARE STAFF)	3,764		3,764	
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS	346,133	-31,690	314,443	
21 ALLOWABLE GME COSTS				
22 SUBTOTAL (SUM OF LINES 15-20)	405,384	-31,690	373,694	
TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	3,145,598	-31,690	3,113,908	
COSTS OTHER THAN RHC/FQHC SERVICES				
23 PHARMACY				
24 DENTAL				
25 OPTOMETRY				
26 ALL OTHER NONREIMBURSABLE COSTS				
27 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
FACILITY OVERHEAD				
29 FACILITY COSTS	27,381		27,381	
30 ADMINISTRATIVE COSTS				
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	27,381		27,381	
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,172,979	-31,690	3,141,289	

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	4.33	15,528	4,200	18,186
3 PHYSICIAN ASSISTANTS	1.83	5,149	2,100	3,843
4 NURSE PRACTITIONERS	4.83	25,189	2,100	10,143
5 SUBTOTAL (SUM OF LINES 1-3)	10.99	45,866		32,172
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	10.99	45,866		
10 PHYSICIAN SERVICES UNDER AGREEMENTS				
11 DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
12 TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)		3,113,908		
13 TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
14 COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)		3,113,908		
15 RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)		1.000000		
16 TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)		27,381		
17 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)		2,392,777		
18 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)		2,420,158		
19 ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
20 SUBTRACT LINE 17 FROM LINE 16		2,420,158		
OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)		2,420,158		
TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)		5,534,066		
		GREATER OF COL. 2 OR COL. 4		
		5		
1 POSITIONS				
2 PHYSICIANS				
3 PHYSICIAN ASSISTANTS				
4 NURSE PRACTITIONERS				
5 SUBTOTAL (SUM OF LINES 1-3)		45,866		
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)		45,866		
10 PHYSICIAN SERVICES UNDER AGREEMENTS				

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	5,534,066	
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)		
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	5,534,066	
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	45,866	
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)		
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	45,866	
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	120.66	

CALCULATION OF LIMIT (1)

		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	72.76	74.29
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	120.66	120.66

10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	5,677	
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	684,987	
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		684,987
16.01	PRIMARY PAYER AMOUNT		163
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		72,249
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		612,575
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		490,060
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		490,060
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		490,060
25	INTERIM PAYMENTS		486,014
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		4,046
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		-11,822

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

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

RHC 1

DESCRIPTION

P A R T B
 MM/DD/YYYY 1 AMOUNT 2

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			498,210
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
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. (1)			
	ADJUSTMENTS TO PROVIDER			.01
	ADJUSTMENTS TO PROVIDER			.02
	ADJUSTMENTS TO PROVIDER			.03
	ADJUSTMENTS TO PROVIDER			.04
	ADJUSTMENTS TO PROVIDER			.05
	ADJUSTMENTS TO PROGRAM	1/15/2007		.50 12,196
	ADJUSTMENTS TO PROGRAM			.51
	ADJUSTMENTS TO PROGRAM			.52
	ADJUSTMENTS TO PROGRAM			.53
	ADJUSTMENTS TO PROGRAM			.54
	ADJUSTMENTS TO PROGRAM			.99
	SUBTOTAL			-12,196
4	TOTAL INTERIM PAYMENTS			486,014
	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. (1)			
	TENTATIVE TO PROVIDER			.01
	TENTATIVE TO PROVIDER			.02
	TENTATIVE TO PROVIDER			.03
	TENTATIVE TO PROGRAM			.50
	TENTATIVE TO PROGRAM			.51
	TENTATIVE TO PROGRAM			.52
	TENTATIVE TO PROGRAM			.99
	SUBTOTAL			NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			
	SETTLEMENT TO PROVIDER			.01
	SETTLEMENT TO PROGRAM			.02
7	TOTAL MEDICARE PROGRAM LIABILITY			

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.