

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).

FORM APPROVED
 OMB NO. 0938-0050

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	I	15-1307	I	FROM 7/ 1/2006	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 6/30/2007	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						I --FINAL 1-MCR CODE	I	
						I 00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/27/2007 TIME 10:04

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 WILLIAMSPORT HOSPITAL 15-1307 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 10:04

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PI ENCRYPTION INFORMATION
 DATE: 11/27/2007 TIME 10:04

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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	5	
1	HOSPITAL	0	23,024	-353,661	0	
3	SWING BED - SNF	0	48,192	0	0	
9	RHC	0	0	610	0	
9 .01	RHC II	0	0	11,304	0	
100	TOTAL	0	71,216	-341,747	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: 412 NORTH MONROE
 1.01 CITY: WILLIAMSPORT P.O. BOX:
 STATE: IN ZIP CODE: 47993- COUNTY: WARREN

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)		
					V	XVIII	XIX
02.00	HOSPITAL	15-1307	2.01	7/ 1/1966	N	O	N
04.00	SWING BED - SNF	15-2307		2/ 1/1988	N	O	N
14.00	HOSPITAL-BASED RHC	15-3993		5/ 6/2001	N	O	N
14.01	HOSPITAL-BASED RHC 2	15-3994		8/ 1/2001	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2006 TO: 6/30/2007

18 TYPE OF CONTROL 1 2
6

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
20 SUBPROVIDER 1

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.

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) N N

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) N N

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 2/ 1/1988

	1	2	3	4
28				
28.01				
28.02	0	0.0000	0.0000	
	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
36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	1	2	3
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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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? N
- 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? N
- 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? N
- 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? N
- 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD? N
- 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS). N

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: 135,840 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					
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.							DATE	Y OR N	LIMIT	Y OR N	FEES
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	1	2	3	4
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.							7/ 1/2006	N	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	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	16	5,840	58,128.00	3	4	1,797	256
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						848	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	16	5,840				2,645	256
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	16	5,840				2,645	256
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-NORTH						2,993	
24 01 RURAL HEALTH CLINIC 2-SOUTH						4,158	
25 TOTAL	16						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS						248	
27 02 AMBULANCE TRIPS						276	
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL ADMITTED	TOTAL OBSERVATION BEDS NOT ADMITTED	INTERNS & RES. FTES / TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	2,411	6.01	6.02	7	8
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			848				
4 ADULTS & PED-SB NF			156				
5 TOTAL ADULTS AND PEDS			3,415				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			3,415				
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-NORTH			13,405				
24 01 RURAL HEALTH CLINIC 2-SOUTH			13,356				
25 TOTAL							
26 OBSERVATION BED DAYS			453	137	316		
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS			11				
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					496	78	740
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		114.31			496	78	740
13 RPCH VISITS							
14 SUBPROVIDER							
15 SKILLED NURSING FACILITY							
16 NURSING FACILITY							
16 01 ICF/MR							
17 OTHER LONG TERM CARE							

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV ---		DISCHARGES			TOTAL ALL PATIENTS
		EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	
18 HOME HEALTH AGENCY	9	10	11	12	13	14	15
20 AMBULATORY SURGICAL CENTER (
21 HOSPICE							
23 CORF							
24 RURAL HEALTH CLINIC-NORTH		14.29					
24 01 RURAL HEALTH CLINIC 2-SOUTH		15.50					
25 TOTAL		144.10					
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: 1731 RINGER LAND
 1.01 CITY: WILLIAMSPORT STATE: IN ZIP CODE: 47993 COUNTY: WARREN
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	PHYSICIAN NAME	BILLING NUMBER
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	FISCHER	1028583A
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	SHARMA	06061480A
		RINGER	1019484A

		PHYSICIAN NAME	HOURS OF SUPERVISION
--	--	----------------	----------------------

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
	0	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO	FROM TO
12	CLINIC	1 2	3 4	5 6	7 8	9 10	11 12	13 14
			730 1700	730 1700	730 1700	730 1630	730 1630	

(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.

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 440 W. SONGER LANE
 1.01 CITY: VEEDERSBURG STATE: IN ZIP CODE: 47987 COUNTY: FOUNTAIN
 2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

	GRANT	AWARD	DATE
	1	2	2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)			/ /
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 NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	HAFAEEZ	1043455A
9.01 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	LUBACK	1057635A

	PHYSICIAN NAME	HOURS OF SUPERVISION
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
12 CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14
			730	1700	730	1700	730	1700	730	1630	730	1630		

(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
1	0100 GENERAL SERVICE COST CNTR					
2	0200 OLD CAP REL COSTS-BLDG & FIXT					
3	0300 NEW CAP REL COSTS-BLDG & FIXT					
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		370,915	370,915	-13,235	357,680
5	0500 EMPLOYEE BENEFITS	34,081	1,996,243	2,030,324	154,734	2,030,324
6	0600 ADMINISTRATIVE & GENERAL	1,073,462	1,073,120	2,146,582	-179,349	1,967,233
7	0700 MAINTENANCE & REPAIRS					
8	0800 OPERATION OF PLANT	118,571	731,577	850,148		850,148
9	0900 LAUNDRY & LINEN SERVICE		40,990	40,990		40,990
10	1000 HOUSEKEEPING	91,805	26,921	118,726		118,726
11	1100 DIETARY		57,867	57,867		57,867
12	1200 CAFETERIA					
13	1300 MAINTENANCE OF PERSONNEL					
14	1400 NURSING ADMINISTRATION	198,101	35,208	233,309	-84,371	148,938
15	1500 CENTRAL SERVICES & SUPPLY		10,376	10,376		10,376
16	1600 PHARMACY	108,819	359,802	468,621		468,621
17	1700 MEDICAL RECORDS & LIBRARY	134,841	52,160	187,001		187,001
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					
26	2600 ADULTS & PEDIATRICS	833,660	135,362	969,022	34,087	1,003,109
27	2700 INTENSIVE CARE UNIT					
28	2800 CORONARY CARE UNIT					
29	2900 BURN INTENSIVE CARE UNIT					
31	3100 SURGICAL INTENSIVE CARE UNIT					
33	3300 SUBPROVIDER					
34	3400 NURSERY					
35	3500 SKILLED NURSING FACILITY					
35.01	3510 NURSING FACILITY					
36	3600 ICF/MR					
37	3700 OTHER LONG TERM CARE					
38	3800 ANCILLARY SRVC COST CNTRS					
39	3900 OPERATING ROOM	354,372	338,343	692,715	-151,673	541,042
40	4000 RECOVERY ROOM					
41	4100 DELIVERY ROOM & LABOR ROOM					
42	4200 ANESTHESIOLOGY					
43	4300 RADIOLOGY-DIAGNOSTIC	488,577	417,434	906,011		906,011
44	4400 RADIOLOGY-THERAPEUTIC					
45	4500 RADIOISOTOPE					
46	4600 LABORATORY	371,070	529,249	900,319		900,319
47	4700 PBP CLINICAL LAB SERVICES-PRGM ONLY					
48	4800 WHOLE BLOOD & PACKED RED BLOOD CELLS					
49	4900 BLOOD STORING, PROCESSING & TRANS.					
50	5000 INTRAVENOUS THERAPY					
51	5100 RESPIRATORY THERAPY	71,376	55,719	127,095	-20,070	107,025
52	5200 PHYSICAL THERAPY	237,287	17,586	254,873	-3,096	251,777
53	5300 OCCUPATIONAL THERAPY					
54	5400 SPEECH PATHOLOGY					
55	5500 ELECTROCARDIOLOGY					
56	5600 ELECTROENCEPHALOGRAPHY					
57	5700 MEDICAL SUPPLIES CHARGED TO PATIENTS				288,636	288,636
58	5800 DRUGS CHARGED TO PATIENTS					
60	6000 RENAL DIALYSIS					
61	6100 ASC (NON-DISTINCT PART)					
62	6200 OUTPAT SERVICE COST CNTRS					
63	6300 CLINIC					
63.50	6310 EMERGENCY	1,494,268	176,325	1,670,593	-63,513	1,607,080
63.51	6311 OBSERVATION BEDS (NON-DISTINCT PART)					
64	6400 OTHER OUTPATIENT SERVICE COST CENTER					
65	6500 RURAL HEALTH CLINIC-NORTH	857,520	124,787	982,307	17,812	1,000,119
66	6600 RURAL HEALTH CLINIC 2-SOUTH	817,490	119,011	936,501	20,038	956,539
67	6700 OTHER REIMBURS COST CNTRS					
68	6800 HOME PROGRAM DIALYSIS					
69	6900 AMBULANCE SERVICES	380,642	42,972	423,614		423,614
70	7000 DURABLE MEDICAL EQUIP-RENTED					
71	7100 DURABLE MEDICAL EQUIP-SOLD					
82	8200 CORF					
83	8300 I&R SERVICES-NOT APPRVD PRGM					
84	8400 HOME HEALTH AGENCY					
85	8500 SPEC PURPOSE COST CENTERS					
85.01	8510 LUNG ACQUISITION					
86	8600 KIDNEY ACQUISITION					
87	8700 LIVER ACQUISITION					
88	8800 HEART ACQUISITION					
89	8900 PANCREAS ACQUISITION					
90	9000 OTHER ORGAN ACQUISITION					
91	9100 INTEREST EXPENSE					
92	9200 UTILIZATION REVIEW-SNF					
93	9300 OTHER CAPITAL RELATED COSTS					
94	9400 AMBULATORY SURGICAL CENTER (D.P.)					
95	9500 HOSPICE					
96	9600 SUBTOTALS	7,665,942	6,803,644	14,469,586	-0-	14,469,586
97	9700 NONREIMBURS COST CENTERS					
98	9800 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
99	9900 RESEARCH	127,334	13,814	141,148		141,148
100	1000 PHYSICIANS' PRIVATE OFFICES					
101	1010 NONPAID WORKERS	18,470	18,164	36,634		36,634
102	1020 OTHER NONREIMBURSABLE COST CENTERS					
103	1030 TOTAL	7,811,746	6,835,622	14,647,368	-0-	14,647,368

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	23,447	381,127
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-58,147	188,264
5	0500 EMPLOYEE BENEFITS	85,619	2,115,943
6	0600 ADMINISTRATIVE & GENERAL	905,763	2,872,996
7	0700 MAINTENANCE & REPAIRS		
8	0800 OPERATION OF PLANT		850,148
9	0900 LAUNDRY & LINEN SERVICE		40,990
10	1000 HOUSEKEEPING		118,726
11	1100 DIETARY		57,867
12	1200 CAFETERIA		
13	1300 MAINTENANCE OF PERSONNEL		
14	1400 NURSING ADMINISTRATION	-200	148,738
15	1500 CENTRAL SERVICES & SUPPLY		10,376
16	1600 PHARMACY		468,621
17	1700 MEDICAL RECORDS & LIBRARY	-3,115	183,886
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 ADULTS & PEDIATRICS		1,003,109
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		
38	3800 OPERATING ROOM	-121,799	419,243
39	3900 RECOVERY ROOM		
40	3900 DELIVERY ROOM & LABOR ROOM		
41	4000 ANESTHESIOLOGY		
42	4100 RADIOLOGY-DIAGNOSTIC		906,011
43	4200 RADIOLOGY-THERAPEUTIC		
44	4300 RADIOISOTOPE		
45	4400 LABORATORY		900,319
46	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY		
47	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		
48	4700 BLOOD STORING, PROCESSING & TRANS.		
49	4800 INTRAVENOUS THERAPY		
50	4900 RESPIRATORY THERAPY	-316	106,709
51	5000 PHYSICAL THERAPY		251,777
52	5100 OCCUPATIONAL THERAPY		
53	5200 SPEECH PATHOLOGY		
54	5300 ELECTROCARDIOLOGY		
55	5400 ELECTROENCEPHALOGRAPHY		
56	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		288,636
57	5600 DRUGS CHARGED TO PATIENTS		
58	5700 RENAL DIALYSIS		
58	5800 ASC (NON-DISTINCT PART)		
60	6000 OUTPAT SERVICE COST CNTRS		
61	6100 CLINIC	-2,400	-2,400
62	6200 EMERGENCY	-372,233	1,234,847
63	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63.50	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.51	6310 RURAL HEALTH CLINIC-NORTH	-109	1,000,010
63.51	6311 RURAL HEALTH CLINIC 2-SOUTH	-109	956,430
64	6400 OTHER REIMBURS COST CNTRS		
65	6400 HOME PROGRAM DIALYSIS		
66	6500 AMBULANCE SERVICES		423,614
67	6600 DURABLE MEDICAL EQUIP-RENTED		
68	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		
83	8200 LUNG ACQUISITION		
84	8300 KIDNEY ACQUISITION		
85	8400 LIVER ACQUISITION		
85.01	8500 HEART ACQUISITION		
86	8510 PANCREAS ACQUISITION		
87	8600 OTHER ORGAN 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	9300 SUBTOTALS	456,401	14,925,987
96	9600 NONREIMBURS COST CENTERS		
97	9700 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 RESEARCH		
99	9800 PHYSICIANS' PRIVATE OFFICES		141,148
100	9900 NONPAID WORKERS		
101	7950 OTHER NONREIMBURSABLE COST CENTERS		36,634
101	TOTAL	456,401	15,103,769

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	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
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-NORTH	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2-SOUTH	6311	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	
86	OTHER ORGAN ACQUISITION	8600	
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	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:
151307

PERIOD:
FROM 7/ 1/2006
TO 6/30/2007

PREPARED 11/27/2007
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		SALARY	OTHER
	(1)	COST CENTER	LINE NO			
	1	2	3		4	5
1 INTEREST	A	NEW CAP REL COSTS-BLDG & FIXT	3			125,191
2		NEW CAP REL COSTS-MVBLE EQUIP	4			54,158
3 DEPRECIATION	B	RURAL HEALTH CLINIC-NORTH	63.50			17,812
4		RURAL HEALTH CLINIC 2-SOUTH	63.51			20,038
5 MEDICAL SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55			288,636
6						
7						
8						
9						
10 DEPRECIATION	E	NEW CAP REL COSTS-MVBLE EQUIP	4			100,576
11 MED-SURG SALARY RECLASS	F	ADULTS & PEDIATRICS	25		84,371	
36 TOTAL RECLASSIFICATIONS					84,371	606,411

(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

PROVIDER NO:
151307

PERIOD:
FROM 7/1/2006
TO 6/30/2007

PREPARED 11/27/2007
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO				
1 INTEREST	A	ADMINISTRATIVE & GENERAL	6			179,349	9
2							
3 DEPRECIATION	B	NEW CAP REL COSTS-BLDG & FIXT	3			37,850	9
4							
5 MEDICAL SUPPLIES	C	ADULTS & PEDIATRICS	25			50,284	
6		OPERATING ROOM	37			151,673	
7		RESPIRATORY THERAPY	49			20,070	
8		PHYSICAL THERAPY	50			3,096	
9		EMERGENCY	61			63,513	
10 DEPRECIATION	E	NEW CAP REL COSTS-BLDG & FIXT	3			100,576	9
11 MED-SURG SALARY RECLASS	F	NURSING ADMINISTRATION	14		84,371		
36 TOTAL RECLASSIFICATIONS					84,371	606,411	

(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 : INTEREST

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	125,191	ADMINISTRATIVE & GENERAL	6	179,349	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	54,158			0	
TOTAL RECLASSIFICATIONS FOR CODE A			179,349	TOTAL RECLASSIFICATIONS FOR CODE A			179,349

RECLASS CODE: B
 EXPLANATION : DEPRECIATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	RURAL HEALTH CLINIC-NORTH	63.50	17,812	NEW CAP REL COSTS-BLDG & FIXT	3	37,850	
2.00	RURAL HEALTH CLINIC 2-SOUTH	63.51	20,038			0	
TOTAL RECLASSIFICATIONS FOR CODE B			37,850	TOTAL RECLASSIFICATIONS FOR CODE B			37,850

RECLASS CODE: C
 EXPLANATION : MEDICAL SUPPLIES

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	288,636	ADULTS & PEDIATRICS	25	50,284	
2.00			0	OPERATING ROOM	37	151,673	
3.00			0	RESPIRATORY THERAPY	49	20,070	
4.00			0	PHYSICAL THERAPY	50	3,096	
5.00			0	EMERGENCY	61	63,513	
TOTAL RECLASSIFICATIONS FOR CODE C			288,636	TOTAL RECLASSIFICATIONS FOR CODE C			288,636

RECLASS CODE: E
 EXPLANATION : DEPRECIATION

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	100,576	NEW CAP REL COSTS-BLDG & FIXT	3	100,576	
TOTAL RECLASSIFICATIONS FOR CODE E			100,576	TOTAL RECLASSIFICATIONS FOR CODE E			100,576

RECLASS CODE: F
 EXPLANATION : MED-SURG SALARY RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADULTS & PEDIATRICS	25	84,371	NURSING ADMINISTRATION	14	84,371	
TOTAL RECLASSIFICATIONS FOR CODE F			84,371	TOTAL RECLASSIFICATIONS FOR CODE F			84,371

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
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	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	174,050					174,050	
2 LAND IMPROVEMENTS	100,546					100,546	
3 BUILDINGS & FIXTURE	6,978,881					6,978,881	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	2,549	2,796		2,796		5,345	
6 MOVABLE EQUIPMENT	3,007,028	301,801		301,801		3,308,829	
7 SUBTOTAL	10,263,054	304,597		304,597		10,567,651	
8 RECONCILING ITEMS							
9 TOTAL	10,263,054	304,597		304,597		10,567,651	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
	GROSS ASSETS	CAPITLIZED LEASES	GROSS ASSETS FOR RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
	1	2	3	4	5	6	7
* 1 OLD CAP REL COSTS-BL							
2 OLD CAP REL COSTS-MV							
3 NEW CAP REL COSTS-BL	7,660,964		7,660,964	.698029			
4 NEW CAP REL COSTS-MV	3,314,174		3,314,174	.301971			
5 TOTAL	10,975,138		10,975,138	1.000000			

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
	9	10	11	12	13	14	15
* 1 OLD CAP REL COSTS-BL							
2 OLD CAP REL COSTS-MV							
3 NEW CAP REL COSTS-BL	381,127						381,127
4 NEW CAP REL COSTS-MV	188,264						188,264
5 TOTAL	569,391						569,391

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST	TOTAL (1)
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
	9	10	11	12	13	14	15
* 1 OLD CAP REL COSTS-BL							
2 OLD CAP REL COSTS-MV							
3 NEW CAP REL COSTS-BL	370,915						370,915
4 NEW CAP REL COSTS-MV	91,677						91,677
5 TOTAL	462,592						462,592

* 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

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST. A-7 REF. 5
			COST CENTER	LINE NO	
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	B	-126,508	NEW CAP REL COSTS-BLDG &	3	9
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-54,728	NEW CAP REL COSTS-MVBLE E	4	9
5 INVESTMENT INCOME-OTHER					
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					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-372,233			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	1,141,167			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
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	-2,712	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		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 MISC REVENUE	B	700	ADMINISTRATIVE & GENERAL	6	
38 RENTAL INCOME	B	-2,400	CLINIC	60	
39 CRNA FEES	A	-121,799	OPERATING ROOM	37	
40					
41 MEDICAL RECORDS	A	-403	MEDICAL RECORDS & LIBRARY	17	
42					
43 ADVERTISING	A	-200	NURSING ADMINISTRATION	14	
44 ADVERTISING	A	-2,390	EMPLOYEE BENEFITS	5	
45 ADVERTISING	A	-109	RURAL HEALTH CLINIC-NORTH	63.50	
46					
47 ADVERTISING	A	-316	RESPIRATORY THERAPY	49	
48 ADVERTISING	A	-109	RURAL HEALTH CLINIC 2-SOU	63.51	
49					
49.01 CHARITABLE EXPENSE	A	-1,559	ADMINISTRATIVE & GENERAL	6	
49.02					
49.03					
49.04					
49.05					
49.06					
49.07					
49.08					
50 TOTAL (SUM OF LINES 1 THRU 49)		456,401			

(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 &	ST. VINCENT HEALTH - HOME	174,156	16,296	157,860	9
2	6	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - HOME	1,001,495	94,392	907,103	
3	14	NURSING ADMINISTRATION	ST. VINCENT HEALTH - CHAR	262	262		
4	17	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHAR	21,221	21,221		
4.01	41	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH - CHAR	13,128	13,128		
4.02	5	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - CHAR	116,960	116,960		
4.03	60	CLINIC	ST. VINCENT HEALTH - CHAR	141	141		
4.04	6	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHAR	451,942	451,942		
4.05	8	OPERATION OF PLANT	ST. VINCENT HEALTH - CHAR	72,251	72,251		
4.08	3	NEW CAP REL COSTS-BLDG &	ASCENSION - INTEREST	117,286	125,191	-7,905	9
4.09	4	NEW CAP REL COSTS-MVBLE E	ASCENSION - INTEREST	50,739	54,158	-3,419	9
4.10	6	ADMINISTRATIVE & GENERAL	ASCENSION - INTEREST	13,212	14,102	-890	
4.12	6	ADMINISTRATIVE & GENERAL	ASCENSION - CHARGEBACK	142,024	142,024		
4.13	6	ADMINISTRATIVE & GENERAL	ASCENSION- MAINTENANCE	245,154	244,745	409	
4.14	5	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - HOME	557,089	469,080	88,009	
5		TOTALS		2,977,060	1,835,893	1,141,167	

* 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		0.00		0.00	
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.

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	61 ER - CONTRACTED	7,162	2,934	4,228				
2	61 ER - SALARIED	901,463	369,299	532,164				
3	37 ANESTHESIA - MEDICAL DIRE	23,269		23,269				
4	44 LAB - MEDICAL DIRECTOR	29,415		29,415				
5	37 SURGERY - MEDICAL DIRECTO	36,000		36,000				
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	997,309	372,233	625,076				

COST ALLOCATION STATISTICS

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
1	OLD CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	NOT ENTERED
2	OLD CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	6	SQUARE FEET	NOT ENTERED
8	OPERATION OF PLANT	7	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	SQUARE FEET	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	MEALS SERVED	NOT ENTERED
13	MAINTENANCE OF PERSONNEL	12	NUMBER HOUSED	NOT ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	ENTERED
16	PHARMACY	15	COSTED REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TOTAL REVENUE	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	NOT ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED TIME	NOT ENTERED
21	NURSING SCHOOL	19	ASSIGNED TIME	NOT ENTERED
22	I&R SERVICES-SALARY & FRINGES APPRVD	20	ASSIGNED TIME	NOT ENTERED
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	21	ASSIGNED TIME	NOT ENTERED
24	PARAMED ED PRGM	22	ASSIGNED TIME	NOT ENTERED

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	6	7	8	9	10	11	12
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL	3,217,570						
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	267,294		1,254,921				
010 LAUNDRY & LINEN SERVICE	11,893		8,977	64,813			
011 HOUSEKEEPING	39,090		2,223		185,746		
012 DIETARY	15,661					73,528	
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	58,300		38,860		5,852		
016 CENTRAL SERVICES & SUPPLY	2,808						
017 PHARMACY	134,841						
018 MEDICAL RECORDS & LIBRARY	66,508		76,522		11,525		
020 SOCIAL SERVICE							
021 NONPHYSICIAN ANESTHETISTS							
022 NURSING SCHOOL							
023 I&R SERVICES-SALARY & FRI							
024 I&R SERVICES-OTHER PRGM C							
025 PARAMED ED PRGM							
026 INPAT ROUTINE SRVC CNTRS							
027 ADULTS & PEDIATRICS	356,682		267,530	32,408	40,293	73,528	
028 INTENSIVE CARE UNIT							
029 CORONARY CARE UNIT							
031 BURN INTENSIVE CARE UNIT							
033 SURGICAL INTENSIVE CARE U							
034 SUBPROVIDER							
035 NURSERY							
036 SKILLED NURSING FACILITY							
037 NURSING FACILITY							
038 01 ICF/MR							
039 OTHER LONG TERM CARE							
040 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM	155,933		183,952	9,722	27,704		
042 RECOVERY ROOM							
043 DELIVERY ROOM & LABOR ROO							
044 ANESTHESIOLOGY							
045 RADIOLOGY-DIAGNOSTIC	292,520		127,394	3,240	19,186		
046 RADIOLOGY-THERAPEUTIC							
047 RADIOISOTOPE							
048 LABORATORY	276,372		60,491		9,110		
049 PBP CLINICAL LAB SERVICES							
050 WHOLE BLOOD & PACKED RED							
051 BLOOD STORING, PROCESSING							
052 INTRAVENOUS THERAPY							
053 RESPIRATORY THERAPY	37,576		38,646		5,820		
054 PHYSICAL THERAPY	92,631		78,831	3,240	11,872		
055 OCCUPATIONAL THERAPY							
056 SPEECH PATHOLOGY							
057 ELECTROCARDIOLOGY							
058 ELECTROENCEPHALOGRAPHY							
060 MEDICAL SUPPLIES CHARGED	80,518		26,975		4,063		
061 DRUGS CHARGED TO PATIENTS	1,808		20,306		3,058		
062 RENAL DIALYSIS							
063 ASC (NON-DISTINCT PART)							
064 OUTPAT SERVICE COST CNTRS							
065 CLINIC							
066 EMERGENCY	454,050		110,337	12,962	16,617		
067 OBSERVATION BEDS (NON-DIS							
068 OTHER OUTPATIENT SERVICE							
069 50 RURAL HEALTH CLINIC-NORTH	333,785			1,766			
063 51 RURAL HEALTH CLINIC 2-SOU	319,042			1,475			
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES	153,832		125,342		18,877		
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
072 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
083 SPEC PURPOSE COST CENTERS							
084 KIDNEY ACQUISITION							
085 LIVER ACQUISITION							
086 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	3,151,144		1,166,386	64,813	173,977	73,528	
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP	618		10,388				
098 RESEARCH							
099 PHYSICIANS' PRIVATE OFFIC	54,438		77,078		11,608		
100 NONPAID WORKERS							
101 OTHER NONREIMBURSABLE COS	11,370		1,069		161		
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
TOTAL	3,217,570		1,254,921	64,813	185,746	73,528	

COST CENTER DESCRIPTION	MAINTENANCE	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
	F PERSONNEL	ISTRATION	ES & SUPPLY		DS & LIBRARY	E	ANESTHETISTS
	13	14	15	16	17	18	20
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION		318,426					
016 CENTRAL SERVICES & SUPPLY			13,184				
017 PHARMACY				633,067			
018 MEDICAL RECORDS & LIBRARY					400,295		
019 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		117,289			21,996		
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
030 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 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		30,246			16,679		
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO							
042 ANESTHESIOLOGY							
043 RADIOLOGY-DIAGNOSTIC					96,770		
044 RADIOLOGY-THERAPEUTIC							
045 RADIOISOTOPE							
046 LABORATORY					99,229		
047 PBP CLINICAL LAB SERVICES							
048 WHOLE BLOOD & PACKED RED							
049 BLOOD STORING, PROCESSING							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY					12,800		
052 PHYSICAL THERAPY					13,043		
053 OCCUPATIONAL THERAPY							
054 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY							
056 ELECTROENCEPHALOGRAPHY							
057 MEDICAL SUPPLIES CHARGED			13,184		11,204		
058 DRUGS CHARGED TO PATIENTS				633,067	26,224		
059 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
063 EMERGENCY		84,921			48,463		
064 OBSERVATION BEDS (NON-DIS							
065 OTHER OUTPATIENT SERVICE							
066 50 RURAL HEALTH CLINIC-NORTH		24,883			18,793		
067 51 RURAL HEALTH CLINIC 2-SOU		46,287			19,991		
068 OTHER REIMBURS COST CNTRS							
069 HOME PROGRAM DIALYSIS							
070 AMBULANCE SERVICES					15,103		
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 OTHER ORGAN ACQUISITION							
083 AMBULATORY SURGICAL CENTE							
084 HOSPICE							
085 SUBTOTALS		303,626	13,184	633,067	400,295		
086 NONREIMBURS COST CENTERS							
087 GIFT, FLOWER, COFFEE SHOP							
088 RESEARCH							
089 PHYSICIANS' PRIVATE OFFIC		14,800					
090 NONPAID WORKERS							
091 OTHER NONREIMBURSABLE COS							
092 CROSS FOOT ADJUSTMENT							
093 NEGATIVE COST CENTER							
094 TOTAL		318,426	13,184	633,067	400,295		

COST CENTER DESCRIPTION	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PRGM	PR	SUBTOTAL	I&R COST POST STEP-DOWN	TOTAL
	21	22	23	24		25	26	27
001 GENERAL SERVICE COST CNTR								
002 OLD CAP REL COSTS-BLDG &								
003 OLD CAP REL COSTS-MVBLE E								
004 NEW CAP REL COSTS-BLDG &								
005 NEW CAP REL COSTS-MVBLE E								
006 EMPLOYEE BENEFITS								
007 ADMINISTRATIVE & GENERAL								
008 MAINTENANCE & REPAIRS								
009 OPERATION OF PLANT								
010 LAUNDRY & LINEN SERVICE								
011 HOUSEKEEPING								
012 DIETARY								
013 CAFETERIA								
014 MAINTENANCE OF PERSONNEL								
015 NURSING ADMINISTRATION								
016 CENTRAL SERVICES & SUPPLY								
017 PHARMACY								
018 MEDICAL RECORDS & LIBRARY								
019 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						2,227,632		2,227,632
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 NURSING FACILITY								
035 01 ICF/MR								
036 OTHER LONG TERM CARE								
037 ANCILLARY SRVC COST CNTRS								
038 OPERATING ROOM						1,000,393		1,000,393
039 RECOVERY ROOM								
040 DELIVERY ROOM & LABOR ROO								
041 ANESTHESIOLOGY								
042 RADIOLOGY-DIAGNOSTIC						1,619,943		1,619,943
043 RADIOLOGY-THERAPEUTIC								
044 RADIOISOTOPE								
045 LABORATORY						1,466,369		1,466,369
046 PBP CLINICAL LAB SERVICES								
047 WHOLE BLOOD & PACKED RED								
048 BLOOD STORING, PROCESSING								
049 INTRAVENOUS THERAPY								
050 RESPIRATORY THERAPY						233,681		233,681
051 PHYSICAL THERAPY						541,878		541,878
052 OCCUPATIONAL THERAPY								
053 SPEECH PATHOLOGY								
054 ELECTROCARDIOLOGY								
055 ELECTROENCEPHALOGRAPHY								
056 MEDICAL SUPPLIES CHARGED						433,452		433,452
057 DRUGS CHARGED TO PATIENTS						691,142		691,142
058 RENAL DIALYSIS								
060 ASC (NON-DISTINCT PART)								
061 OUTPAT SERVICE COST CNTRS								
062 CLINIC						-2,400		-2,400
063 EMERGENCY						2,405,008		2,405,008
064 OBSERVATION BEDS (NON-DIS								
065 OTHER OUTPATIENT SERVICE								
066 50 RURAL HEALTH CLINIC-NORTH						1,612,529		1,612,529
067 51 RURAL HEALTH CLINIC 2-SOU						1,565,626		1,565,626
068 OTHER REIMBURS COST CNTRS								
069 HOME PROGRAM DIALYSIS								
070 AMBULANCE SERVICES						881,550		881,550
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 OTHER ORGAN ACQUISITION								
083 AMBULATORY SURGICAL CENTE								
084 HOSPICE								
085 SUBTOTALS						14,676,803		14,676,803
086 NONREIMBURS COST CENTERS								
087 GIFT, FLOWER, COFFEE SHOP						13,289		13,289
088 RESEARCH								
089 PHYSICIANS' PRIVATE OFFIC						359,066		359,066
090 NONPAID WORKERS								
091 OTHER NONREIMBURSABLE COS						54,611		54,611
092 CROSS FOOT ADJUSTMENT								
093 NEGATIVE COST CENTER								
094 TOTAL						15,103,769		15,103,769

COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	OLD CAP REL C OSTS-BLDG &	OLD CAP REL C OSTS-MVBLE E	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS
	0	1	2	3	4	4a	5
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS				35,094	17,440	52,534	
008 OPERATION OF PLANT				70,290	34,931	105,221	
009 LAUNDRY & LINEN SERVICE				1,973	980	2,953	
010 HOUSEKEEPING				488	243	731	
011 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION				8,539	4,243	12,782	
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY				16,814	8,356	25,170	
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 ADULTS & PEDIATRICS				58,784	29,212	87,996	
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							
038 OPERATING ROOM				40,420	20,086	60,506	
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC				27,992	13,911	41,903	
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY				13,292	6,605	19,897	
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY				8,492	4,220	12,712	
051 PHYSICAL THERAPY				17,321	8,608	25,929	
052 OCCUPATIONAL THERAPY							
053 SPEECH PATHOLOGY							
054 ELECTROCARDIOLOGY							
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED				5,927	2,945	8,872	
057 DRUGS CHARGED TO PATIENTS				4,462	2,217	6,679	
058 RENAL DIALYSIS							
060 ASC (NON-DISTINCT PART)							
061 OUTPAT SERVICE COST CNTRS							
062 CLINIC							
062 EMERGENCY				24,244	12,048	36,292	
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC-NORTH	25,682					25,682	
063 51 RURAL HEALTH CLINIC 2-SOU	25,487					25,487	
064 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES				27,541	13,686	41,227	
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							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	51,169			361,673	179,731	592,573	
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP				2,283		2,283	
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC				16,936	8,416	25,352	
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS				235	117	352	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	51,169			381,127	188,264	620,560	

COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	6	7	8	9	10	11	12
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL	52,534						
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	4,364		109,585				
010 LAUNDRY & LINEN SERVICE			194	3,931			
011 HOUSEKEEPING			784		1,563		
012 DIETARY			194				
013 CAFETERIA							256
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	952		3,393		49		
016 CENTRAL SERVICES & SUPPLY	46						
017 PHARMACY	2,202						
018 MEDICAL RECORDS & LIBRARY	1,086		6,682		97		
019 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	5,824		23,362	1,965	339	256	
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
030 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
032 NURSERY							
033 SKILLED NURSING FACILITY							
034 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM	2,546		16,064	590	233		
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	4,776		11,125	197	161		
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY	4,513		5,282		77		
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY	614		3,375		49		
051 PHYSICAL THERAPY	1,512		6,884	197	100		
052 OCCUPATIONAL THERAPY							
053 SPEECH PATHOLOGY							
054 ELECTROCARDIOLOGY							
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED	1,315		2,356		34		
057 DRUGS CHARGED TO PATIENTS	30		1,773		26		
058 RENAL DIALYSIS							
059 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY	7,410		9,635	786	140		
063 OBSERVATION BEDS (NON-DIS							
064 OTHER OUTPATIENT SERVICE							
065 50 RURAL HEALTH CLINIC-NORTH	5,450			107			
066 51 RURAL HEALTH CLINIC 2-SOU	5,209			89			
067 OTHER REIMBURS COST CNTRS							
068 HOME PROGRAM DIALYSIS							
069 AMBULANCE SERVICES	2,512		10,945		159		
070 DURABLE MEDICAL EQUIP-REN							
071 DURABLE MEDICAL EQUIP-SOL							
072 CORF							
073 I&R SERVICES-NOT APPRVD P							
074 HOME HEALTH AGENCY							
075 LUNG ACQUISITION							
076 SPEC PURPOSE COST CENTERS							
077 KIDNEY ACQUISITION							
078 LIVER ACQUISITION							
079 HEART ACQUISITION							
080 01 PANCREAS ACQUISITION							
081 OTHER ORGAN ACQUISITION							
082 AMBULATORY SURGICAL CENTE							
083 HOSPICE							
084 SUBTOTALS	51,449		101,854	3,931	1,464	256	
085 NONREIMBURS COST CENTERS							
086 GIFT, FLOWER, COFFEE SHOP	10		907				
087 RESEARCH							
088 PHYSICIANS' PRIVATE OFFIC	889		6,731		98		
089 NONPAID WORKERS							
090 OTHER NONREIMBURSABLE COS	186		93		1		
091 CROSS FOOT ADJUSTMENTS							
092 NEGATIVE COST CENTER							
093 TOTAL	52,534		109,585	3,931	1,563	256	

COST CENTER DESCRIPTION	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PRGM	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	21	22	23	24	25	26	27
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT							
010 LAUNDRY & LINEN SERVICE							
011 HOUSEKEEPING							
012 DIETARY							
013 CAFETERIA							
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION							
016 CENTRAL SERVICES & SUPPLY							
017 PHARMACY							
018 MEDICAL RECORDS & LIBRARY							
019 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					127,884		127,884
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 NURSING FACILITY							
01 ICF/MR							
037 OTHER LONG TERM CARE							
038 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM					82,946		82,946
040 RECOVERY ROOM							
041 DELIVERY ROOM & LABOR ROO							
042 ANESTHESIOLOGY							
043 RADIOLOGY-DIAGNOSTIC					66,147		66,147
044 RADIOLOGY-THERAPEUTIC							
045 RADIOISOTOPE							
046 LABORATORY					37,961		37,961
047 PBP CLINICAL LAB SERVICES							
048 WHOLE BLOOD & PACKED RED							
049 BLOOD STORING, PROCESSING							
050 INTRAVENOUS THERAPY							
051 RESPIRATORY THERAPY					17,806		17,806
052 PHYSICAL THERAPY					35,698		35,698
053 OCCUPATIONAL THERAPY							
054 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY							
056 ELECTROENCEPHALOGRAPHY							
057 MEDICAL SUPPLIES CHARGED					13,548		13,548
058 DRUGS CHARGED TO PATIENTS					12,874		12,874
060 RENAL DIALYSIS							
061 ASC (NON-DISTINCT PART)							
062 OUTPAT SERVICE COST CNTRS							
063 CLINIC							
064 EMERGENCY					62,843		62,843
065 OBSERVATION BEDS (NON-DIS							
066 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC-NORTH					34,132		34,132
063 51 RURAL HEALTH CLINIC 2-SOU					34,932		34,932
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES					56,089		56,089
067 DURABLE MEDICAL EQUIP-REN							
069 DURABLE MEDICAL EQUIP-SOL							
070 CORF							
071 I&R SERVICES-NOT APPRVD P							
082 HOME HEALTH AGENCY							
083 LUNG ACQUISITION							
084 SPEC PURPOSE COST CENTERS							
085 KIDNEY ACQUISITION							
086 LIVER ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS					582,860		582,860
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP					3,200		3,200
098 RESEARCH							
099 PHYSICIANS' PRIVATE OFFIC					33,868		33,868
100 NONPAID WORKERS							
101 OTHER NONREIMBURSABLE COS					632		632
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
TOTAL					620,560		620,560

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION
	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (DOLLAR VALUE)	OSTS-BLDG & (SQUARE FEET)	OSTS-MVBLE E (SQUARE FEET)	FITS (GROSS SALARIES)	
	1	2	3	4	5	6a.00
001 GENERAL SERVICE COST CNTR						
002 OLD CAP REL COSTS-BLDG &						
003 OLD CAP REL COSTS-MVBLE E						
004 NEW CAP REL COSTS-BLDG &			40,574			
005 NEW CAP REL COSTS-MVBLE E					40,331	
006 EMPLOYEE BENEFITS					7,777,665	
007 ADMINISTRATIVE & GENERAL			3,736	3,736	1,073,462	-3,217,570
008 MAINTENANCE & REPAIRS						
009 OPERATION OF PLANT			7,483	7,483	118,571	
010 LAUNDRY & LINEN SERVICE			210	210		
011 HOUSEKEEPING			52	52	91,805	
012 DIETARY						
013 CAFETERIA						
014 MAINTENANCE OF PERSONNEL						
015 NURSING ADMINISTRATION			909	909	198,101	
016 CENTRAL SERVICES & SUPPLY						
017 PHARMACY					108,819	
018 MEDICAL RECORDS & LIBRARY			1,790	1,790	134,841	
019 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			6,258	6,258	833,660	
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
029 BURN INTENSIVE CARE UNIT						
030 SURGICAL INTENSIVE CARE U						
031 SUBPROVIDER						
032 NURSERY						
033 SKILLED NURSING FACILITY						
034 NURSING FACILITY						
035 01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST CNTRS						
038 OPERATING ROOM			4,303	4,303	354,372	
039 RECOVERY ROOM						
040 DELIVERY ROOM & LABOR ROO						
041 ANESTHESIOLOGY						
042 RADIOLOGY-DIAGNOSTIC			2,980	2,980	488,577	
043 RADIOLOGY-THERAPEUTIC						
044 RADIOISOTOPE						
045 LABORATORY			1,415	1,415	371,070	
046 PBP CLINICAL LAB SERVICES						
047 WHOLE BLOOD & PACKED RED						
048 BLOOD STORING, PROCESSING						
049 INTRAVENOUS THERAPY						
050 RESPIRATORY THERAPY			904	904	71,376	
051 PHYSICAL THERAPY			1,844	1,844	237,287	
052 OCCUPATIONAL THERAPY						
053 SPEECH PATHOLOGY						
054 ELECTROCARDIOLOGY						
055 ELECTROENCEPHALOGRAPHY						
056 MEDICAL SUPPLIES CHARGED			631	631		
057 DRUGS CHARGED TO PATIENTS			475	475		
058 RENAL DIALYSIS						
059 ASC (NON-DISTINCT PART)						
060 OUTPAT SERVICE COST CNTRS						
061 CLINIC						
062 EMERGENCY			2,581	2,581	1,494,268	2,400
063 OBSERVATION BEDS (NON-DIS						
064 OTHER OUTPATIENT SERVICE						
065 50 RURAL HEALTH CLINIC-NORTH					857,520	
066 51 RURAL HEALTH CLINIC 2-SOU					817,490	
067 OTHER REIMBURS COST CNTRS						
068 HOME PROGRAM DIALYSIS						
069 AMBULANCE SERVICES			2,932	2,932	380,642	
070 DURABLE MEDICAL EQUIP-REN						
071 DURABLE MEDICAL EQUIP-SOL						
072 CORF						
073 I&R SERVICES-NOT APPRVD P						
074 HOME HEALTH AGENCY						
075 LUNG ACQUISITION						
076 SPEC PURPOSE COST CENTERS						
077 KIDNEY ACQUISITION						
078 LIVER ACQUISITION						
079 HEART ACQUISITION						
080 01 PANCREAS ACQUISITION						
081 OTHER ORGAN ACQUISITION						
082 AMBULATORY SURGICAL CENTE						
083 HOSPICE						
084 SUBTOTALS			38,503	38,503	7,631,861	-3,215,170
085 NONREIMBURS COST CENTERS						
086 GIFT, FLOWER, COFFEE SHOP			243			
087 RESEARCH						
088 PHYSICIANS' PRIVATE OFFIC			1,803	1,803	127,334	
089 NONPAID WORKERS						
090 OTHER NONREIMBURSABLE COS			25	25	18,470	
091 CROSS FOOT ADJUSTMENT						

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION
	OSTS-BLDG &	OSTS-MVBLE E	OSTS-BLDG &	OSTS-MVBLE E	FITS	
	(SQUARE FEET)	(DOLLAR VALUE)	(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARIES)	
	1	2	3	4	5	6a.00
NONREIMBURS COST CENTERS						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (WRKSHT B, PART I)			381,127	188,264	2,115,943	
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)			9.393380	4.667973	.272054	
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	ADMINISTRATIVE & GENERAL	MAINTENANCE REPAIRS	& OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(MEALS SERVED)
		6	7	8	9	10	11	12
102	NONREIMBURS COST CENTERS							
103	NEGATIVE COST CENTER COST TO BE ALLOCATED (WRKSHT B, PART I)	3,217,570		1,254,921	64,813	185,746	73,528	
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	.270643		42.749821	.821603	6.438336	735.280000	
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)	52,534		109,585	3,931	1,563	256	
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.004419		3.733095	.049831	.054177	2.560000	

COST CENTER DESCRIPTION	MAINTENANCE	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC	NONPHYSICIAN
	F PERSONNEL	ISTRATION	CES & SUPPLY		DS & LIBRARY	E	ANESTHETISTS
	(NUMBER HOUSED)	(DIRECT NRSING HRS)	(COSTED REQUIS.)	(COSTED REQUIS.)	(TOTAL REVENUE)	(TIME SPENT)	(ASSIGNED TIME)
	13	14	15	16	17	18	20
NONREIMBURS COST CENTERS							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED (WRKSHT B, PART I)		318,426	13,184	633,067	400,295		
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)		4.449839	131.840000	6,330.670000	.011489		
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)		17,176	46	2,202	33,035		
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)		.240026	.460000	22.020000	.000948		

COST CENTER DESCRIPTION	NURSING SCHOO	I&R SERVICES-	I&R SERVICES-	PARAMED ED PR
	L	SALARY & FRI	OTHER PRGM C	GM
	(ASSIGNED TIME)			
	21	22	23	24
001 GENERAL SERVICE COST CNTR				
002 OLD CAP REL COSTS-BLDG &				
003 OLD CAP REL COSTS-MVBLE E				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
007 ADMINISTRATIVE & GENERAL				
008 MAINTENANCE & REPAIRS				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
013 CAFETERIA				
014 MAINTENANCE OF PERSONNEL				
015 NURSING ADMINISTRATION				
016 CENTRAL SERVICES & SUPPLY				
017 PHARMACY				
018 MEDICAL RECORDS & LIBRARY				
019 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				
030 SURGICAL INTENSIVE CARE U				
031 SUBPROVIDER				
032 NURSERY				
033 SKILLED NURSING FACILITY				
034 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				
059 ASC (NON-DISTINCT PART)				
060 OUTPAT SERVICE COST CNTRS				
061 CLINIC				
062 EMERGENCY				
063 OBSERVATION BEDS (NON-DIS				
063 50 OTHER OUTPATIENT SERVICE				
063 51 RURAL HEALTH CLINIC-NORTH				
063 51 RURAL HEALTH CLINIC 2-SOU				
064 OTHER REIMBURS COST CNTRS				
065 HOME PROGRAM DIALYSIS				
066 AMBULANCE SERVICES				
067 DURABLE MEDICAL EQUIP-REN				
068 DURABLE MEDICAL EQUIP-SOL				
069 CORF				
070 I&R SERVICES-NOT APPRVD P				
071 HOME HEALTH AGENCY				
072 LUNG ACQUISITION				
073 SPEC PURPOSE COST CENTERS				
074 KIDNEY ACQUISITION				
075 LIVER ACQUISITION				
076 HEART ACQUISITION				
077 01 PANCREAS ACQUISITION				
078 OTHER ORGAN 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 OTHER NONREIMBURSABLE COS				
088 CROSS FOOT ADJUSTMENT				

COST CENTER DESCRIPTION	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM	PARAMED ED PRGM
	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)	(ASSIGNED TIME)
NONREIMBURS COST CENTERS	21	22	23	24
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)				

COMPUTATION OF RATIO OF COSTS TO CHARGES

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					
26	ADULTS & PEDIATRICS	2,227,632		2,227,632		
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	1,000,393		1,000,393		
39	RECOVERY ROOM					
40	DELIVERY ROOM & LABOR ROO					
41	ANESTHESIOLOGY					
42	RADIOLOGY-DIAGNOSTIC	1,619,943		1,619,943		
43	RADIOLOGY-THERAPEUTIC					
44	RADIOISOTOPE					
45	LABORATORY	1,466,369		1,466,369		
46	PBP CLINICAL LAB SERVICES					
47	WHOLE BLOOD & PACKED RED					
48	BLOOD STORING, PROCESSING					
49	INTRAVENOUS THERAPY					
50	RESPIRATORY THERAPY	233,681		233,681		
51	PHYSICAL THERAPY	541,878		541,878		
52	OCCUPATIONAL THERAPY					
53	SPEECH PATHOLOGY					
54	ELECTROCARDIOLOGY					
55	ELECTROENCEPHALOGRAPHY					
56	MEDICAL SUPPLIES CHARGED	433,452		433,452		
57	DRUGS CHARGED TO PATIENTS	691,142		691,142		
58	RENAL DIALYSIS					
59	ASC (NON-DISTINCT PART)					
60	OUTPAT SERVICE COST CNTRS					
61	CLINIC					
62	EMERGENCY	2,405,008		2,405,008		
63	OBSERVATION BEDS (NON-DIS	269,304		269,304		
64	OTHER OUTPATIENT SERVICE					
65	50 RURAL HEALTH CLINIC-NORTH	1,612,529		1,612,529		
66	51 RURAL HEALTH CLINIC 2-SOU	1,565,626		1,565,626		
67	OTHER REIMBURS COST CNTRS					
68	HOME PROGRAM DIALYSIS					
69	AMBULANCE SERVICES	881,550		881,550		
70	DURABLE MEDICAL EQUIP-REN					
71	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	14,948,507		14,948,507		
102	LESS OBSERVATION BEDS	269,304		269,304		
103	TOTAL	14,679,203		14,679,203		

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	1,914,532		1,914,532			
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	225,066	1,226,700	1,451,766	.689087	.689087	
38	RECOVERY ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC	550,155	7,872,643	8,422,798	.192328	.192328	
42	RADIOLOGY-THERAPEUTIC						
43	RADIOISOTOPE						
44	LABORATORY	1,041,031	7,595,289	8,636,320	.169791	.169791	
45	PBP CLINICAL LAB SERVICES						
46	WHOLE BLOOD & PACKED RED						
47	BLOOD STORING, PROCESSING						
48	INTRAVENOUS THERAPY						
49	RESPIRATORY THERAPY	414,797	699,299	1,114,096	.209749	.209749	
50	PHYSICAL THERAPY	259,489	875,779	1,135,268	.477313	.477313	
51	OCCUPATIONAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	594,117	381,094	975,211	.444470	.444470	
56	DRUGS CHARGED TO PATIENTS	1,144,834	1,137,672	2,282,506	.302800	.302800	
57	RENAL DIALYSIS						
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY	109,998	4,108,196	4,218,194	.570151	.570151	
62	OBSERVATION BEDS (NON-DIS		281,325	281,325	.957270	.957270	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC-NORTH	217,024	1,418,751	1,635,775	.985789	.985789	
63	51 RURAL HEALTH CLINIC 2-SOU	265,853	1,474,157	1,740,010	.899780	.899780	
	OTHER REIMBURS COST CNTRS						
64	HOME PROGRAM DIALYSIS						
65	AMBULANCE SERVICES	172,432	1,142,132	1,314,564	.670603	.670603	
66	DURABLE MEDICAL EQUIP-REN						
67	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	6,909,328	28,213,037	35,122,365			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,909,328	28,213,037	35,122,365			

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	2,227,632		2,227,632		
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					
36	01 ICF/MR					
37	OTHER LONG TERM CARE					
38	ANCILLARY SRVC COST CNTRS					
39	OPERATING ROOM	1,000,393		1,000,393		
40	RECOVERY ROOM					
41	DELIVERY ROOM & LABOR ROO					
42	ANESTHESIOLOGY					
43	RADIOLOGY-DIAGNOSTIC	1,619,943		1,619,943		
44	RADIOLOGY-THERAPEUTIC					
45	RADIOISOTOPE					
46	LABORATORY	1,466,369		1,466,369		
47	PBP CLINICAL LAB SERVICES					
48	WHOLE BLOOD & PACKED RED					
49	BLOOD STORING, PROCESSING					
50	INTRAVENOUS THERAPY					
51	RESPIRATORY THERAPY	233,681		233,681		
52	PHYSICAL THERAPY	541,878		541,878		
53	OCCUPATIONAL THERAPY					
54	SPEECH PATHOLOGY					
55	ELECTROCARDIOLOGY					
56	ELECTROENCEPHALOGRAPHY					
57	MEDICAL SUPPLIES CHARGED	433,452		433,452		
58	DRUGS CHARGED TO PATIENTS	691,142		691,142		
59	RENAL DIALYSIS					
60	ASC (NON-DISTINCT PART)					
61	OUTPAT SERVICE COST CNTRS					
62	CLINIC					
63	EMERGENCY	2,405,008		2,405,008		
64	OBSERVATION BEDS (NON-DIS	269,304		269,304		
65	OTHER OUTPATIENT SERVICE					
66	50 RURAL HEALTH CLINIC-NORTH	1,612,529		1,612,529		
67	51 RURAL HEALTH CLINIC 2-SOU	1,565,626		1,565,626		
68	OTHER REIMBURS COST CNTRS					
69	HOME PROGRAM DIALYSIS					
70	AMBULANCE SERVICES	881,550		881,550		
71	DURABLE MEDICAL EQUIP-REN					
72	DURABLE MEDICAL EQUIP-SOL					
73	SUBTOTAL	14,948,507		14,948,507		
74	LESS OBSERVATION BEDS	269,304		269,304		
75	TOTAL	14,679,203		14,679,203		

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	1,914,532		1,914,532			
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	225,066	1,226,700	1,451,766	.689087	.689087	
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	550,155	7,872,643	8,422,798	.192328	.192328	
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	1,041,031	7,595,289	8,636,320	.169791	.169791	
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	414,797	699,299	1,114,096	.209749	.209749	
51	PHYSICAL THERAPY	259,489	875,779	1,135,268	.477313	.477313	
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY						
54	ELECTROCARDIOLOGY						
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	594,117	381,094	975,211	.444470	.444470	
57	DRUGS CHARGED TO PATIENTS	1,144,834	1,137,672	2,282,506	.302800	.302800	
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	109,998	4,108,196	4,218,194	.570151	.570151	
63	OBSERVATION BEDS (NON-DIS		281,325	281,325	.957270	.957270	
64	OTHER OUTPATIENT SERVICE						
65	50 RURAL HEALTH CLINIC-NORTH	217,024	1,418,751	1,635,775	.985789	.985789	
66	51 RURAL HEALTH CLINIC 2-SOU	265,853	1,474,157	1,740,010	.899780	.899780	
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES	172,432	1,142,132	1,314,564	.670603	.670603	
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	6,909,328	28,213,037	35,122,365			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,909,328	28,213,037	35,122,365			

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	1,000,393	82,946	917,447			1,000,393
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	1,619,943	66,147	1,553,796			1,619,943
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	1,466,369	37,961	1,428,408			1,466,369
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	233,681	17,806	215,875			233,681
51	PHYSICAL THERAPY	541,878	35,698	506,180			541,878
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY						
54	ELECTROCARDIOLOGY						
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	433,452	13,548	419,904			433,452
57	DRUGS CHARGED TO PATIENTS	691,142	12,874	678,268			691,142
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,405,008	62,843	2,342,165			2,405,008
63	OBSERVATION BEDS (NON-DIS	269,304		269,304			269,304
64	OTHER OUTPATIENT SERVICE						
65	50 RURAL HEALTH CLINIC-NORTH	1,612,529	34,132	1,578,397			1,612,529
66	51 RURAL HEALTH CLINIC 2-SOU	1,565,626	34,932	1,530,694			1,565,626
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES	881,550	56,089	825,461			881,550
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
72	SUBTOTAL	12,720,875	454,976	12,265,899			12,720,875
73	LESS OBSERVATION BEDS	269,304		269,304			269,304
74	TOTAL	12,451,571	454,976	11,996,595			12,451,571

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	1,451,766	.689087	.689087
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	8,422,798	.192328	.192328
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	8,636,320	.169791	.169791
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	1,114,096	.209749	.209749
51	PHYSICAL THERAPY	1,135,268	.477313	.477313
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY			
54	ELECTROCARDIOLOGY			
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	975,211	.444470	.444470
57	DRUGS CHARGED TO PATIENTS	2,282,506	.302800	.302800
58	RENAL DIALYSIS			
59	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
62	EMERGENCY	4,218,194	.570151	.570151
63	OBSERVATION BEDS (NON-DIS	281,325	.957270	.957270
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC-NORTH	1,635,775	.985789	.985789
63	51 RURAL HEALTH CLINIC 2-SOU	1,740,010	.899780	.899780
64	OTHER REIMBURS COST CNTRS			
65	HOME PROGRAM DIALYSIS			
66	AMBULANCE SERVICES	1,314,564	.670603	.670603
67	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	33,207,833		
102	LESS OBSERVATION BEDS	281,325		
103	TOTAL	32,926,508		

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 REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
38	OPERATING ROOM	1,000,393	82,946	917,447			1,000,393
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	1,619,943	66,147	1,553,796			1,619,943
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	1,466,369	37,961	1,428,408			1,466,369
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	233,681	17,806	215,875			233,681
51	PHYSICAL THERAPY	541,878	35,698	506,180			541,878
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY						
54	ELECTROCARDIOLOGY						
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	433,452	13,548	419,904			433,452
57	DRUGS CHARGED TO PATIENTS	691,142	12,874	678,268			691,142
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,405,008	62,843	2,342,165			2,405,008
63	OBSERVATION BEDS (NON-DIS	269,304		269,304			269,304
64	OTHER OUTPATIENT SERVICE						
65	RURAL HEALTH CLINIC-NORTH	1,612,529	34,132	1,578,397			1,612,529
66	RURAL HEALTH CLINIC 2-SOU	1,565,626	34,932	1,530,694			1,565,626
67	OTHER REIMBURS COST CNTRS						
68	HOME PROGRAM DIALYSIS						
69	AMBULANCE SERVICES	881,550	56,089	825,461			881,550
70	DURABLE MEDICAL EQUIP-REN						
71	DURABLE MEDICAL EQUIP-SOL						
72	SUBTOTAL	12,720,875	454,976	12,265,899			12,720,875
73	LESS OBSERVATION BEDS	269,304		269,304			269,304
74	TOTAL	12,451,571	454,976	11,996,595			12,451,571

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			
	OPERATING ROOM	1,451,766	.689087	.689087
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROO			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	8,422,798	.192328	.192328
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	8,636,320	.169791	.169791
45	PBP CLINICAL LAB SERVICES			
46	WHOLE BLOOD & PACKED RED			
47	BLOOD STORING, PROCESSING			
48	INTRAVENOUS THERAPY			
49	RESPIRATORY THERAPY	1,114,096	.209749	.209749
50	PHYSICAL THERAPY	1,135,268	.477313	.477313
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	975,211	.444470	.444470
56	DRUGS CHARGED TO PATIENTS	2,282,506	.302800	.302800
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	4,218,194	.570151	.570151
62	OBSERVATION BEDS (NON-DIS	281,325	.957270	.957270
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC-NORTH	1,635,775	.985789	.985789
63	51 RURAL HEALTH CLINIC 2-SOU	1,740,010	.899780	.899780
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES	1,314,564	.670603	.670603
66	DURABLE MEDICAL EQUIP-REN			
67	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	33,207,833		
102	LESS OBSERVATION BEDS	281,325		
103	TOTAL	32,926,508		

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	.689087		.689087		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.192328		.192328		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.169791		.169791		
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	.209749		.209749		
50 PHYSICAL THERAPY	.477313		.477313		
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.444470		.444470		
56 DRUGS CHARGED TO PATIENTS	.302800		.302800		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY	.570151		.570151		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.957270		.957270		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC-NORTH					
63 51 RURAL HEALTH CLINIC 2-SOUTH					
63 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES	.670603		.670603		
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		447,103			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		2,410,044			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		3,248,401			
45 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47 BLOOD STORING, PROCESSING & TRANS.					
48 INTRAVENOUS THERAPY		375,443			
49 RESPIRATORY THERAPY		419,765			
50 PHYSICAL THERAPY					
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		94,481			
56 DRUGS CHARGED TO PATIENTS		701,842			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
62 EMERGENCY		1,464,563			
63 OBSERVATION BEDS (NON-DISTINCT PART)		135,491			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC-NORTH					
63 51 RURAL HEALTH CLINIC 2-SOUTH					
64 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL		9,297,133			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		9,297,133			

(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	308,093		
38 RECOVERY ROOM			
39 DELIVERY ROOM & LABOR ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC	463,519		
42 RADIOLOGY-THERAPEUTIC			
43 RADIOISOTOPE			
44 LABORATORY	551,549		
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	78,749		
50 PHYSICAL THERAPY	200,359		
51 OCCUPATIONAL THERAPY			
52 SPEECH PATHOLOGY			
53 ELECTROCARDIOLOGY			
54 ELECTROENCEPHALOGRAPHY			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	41,994		
56 DRUGS CHARGED TO PATIENTS	212,518		
57 RENAL DIALYSIS			
58 ASC (NON-DISTINCT PART)			
60 OUTPAT SERVICE COST CNTRS			
61 CLINIC			
61 EMERGENCY	835,022		
62 OBSERVATION BEDS (NON-DISTINCT PART)	129,701		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC-NORTH			
63 51 RURAL HEALTH CLINIC 2-SOUTH			
OTHER REIMBURS COST CNTRS			
64 HOME PROGRAM DIALYSIS			
65 AMBULANCE SERVICES			
66 DURABLE MEDICAL EQUIP-RENTED			
67 DURABLE MEDICAL EQUIP-SOLD			
101 SUBTOTAL	2,821,504		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104 NET CHARGES	2,821,504		

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,868
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,864
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,864
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	432
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	416
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	78
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	78
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,797
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	432
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	416
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	131.18
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	136.64
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,227,632
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10,232
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	10,658
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	525,018
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,702,614

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,195,860
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,195,860
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.775375
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	766.71
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,702,614

TITLE XVIII PART A 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					594.49
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,068,299
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,068,299
		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					1 629,582
49	TOTAL PROGRAM INPATIENT COSTS					1,697,881
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 REPORTING PERIOD (SEE INSTRUCTIONS)					256,820
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					247,308
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS					504,128
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	453
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	594.49
85	OBSERVATION BED COST	269,304

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 I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,868
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,864
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,864
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	848
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	156
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	256
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,195,860
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,195,860
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	766.71
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

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					
44 HOSPITAL UNITS					
45 INTENSIVE CARE UNIT					
46 CORONARY CARE UNIT					
47 BURN INTENSIVE CARE UNIT					
48 SURGICAL INTENSIVE CARE UNIT					
49 OTHER SPECIAL CARE					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					185,310
49 TOTAL PROGRAM INPATIENT COSTS					185,310

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 185,310

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 78
 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	453
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				

WKST A LINE NO.	COST CENTER DESCRIPTION	HOSPITAL		OTHER
		RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,142,526	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.689087	67,374	46,427
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.192328	310,541	59,726
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.169791	591,690	100,464
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	.209749	266,044	55,802
50	PHYSICAL THERAPY	.477313	94,686	45,195
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.444470	348,295	154,807
56	DRUGS CHARGED TO PATIENTS	.302800	552,050	167,161
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.570151		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.957270		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC-NORTH			
63	51 RURAL HEALTH CLINIC 2-SOUTH			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP--SOLD			
101	TOTAL		2,230,680	629,582
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,230,680	

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 ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.689087	3,990	2,749
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.192328	49,752	9,569
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.169791	133,408	22,651
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	.209749	75,474	15,831
50	PHYSICAL THERAPY	.477313	140,250	66,943
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.444470	132,296	58,802
56	DRUGS CHARGED TO PATIENTS	.302800	310,477	94,012
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.570151		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.957270		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC-NORTH			
63	51 RURAL HEALTH CLINIC 2-SOUTH			
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		845,647	270,557
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		845,647	

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		180,522	
26	INTENSIVE CARE UNIT			
27	CORONARY CARE UNIT			
28	BURN INTENSIVE CARE UNIT			
29	SURGICAL INTENSIVE CARE UNIT			
31	SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.689087	64,285	44,298
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.192328	95,578	18,382
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.169791	122,200	20,748
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	.209749	65,504	13,739
50	PHYSICAL THERAPY	.477313	2,746	1,311
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY			
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.444470		
56	DRUGS CHARGED TO PATIENTS	.302800	124,644	37,742
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.570151	84,262	48,042
62	OBSERVATION BEDS (NON-DISTINCT PART)	.957270		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC-NORTH	.985789	829	817
63	51 RURAL HEALTH CLINIC 2-SOUTH	.899780	257	231
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		560,305	185,310
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		560,305	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,821,545
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)	2,821,545
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)	2,849,760
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	31,445
18.01	CAH ACTUAL BILLED COINSURANCE	1,207,958
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,610,357
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	1,610,357
24	PRIMARY PAYER PAYMENTS	1,810
25	SUBTOTAL	1,608,547
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	362,681
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	362,681
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	259,826
28	SUBTOTAL	1,971,228
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	1,971,228
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,324,889
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-353,661
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) 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		1,381,320		2,625,174
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
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	19,780		
	ADJUSTMENTS TO PROVIDER	.02			
	ADJUSTMENTS TO PROVIDER	.03			
	ADJUSTMENTS TO PROVIDER	.04			
	ADJUSTMENTS TO PROVIDER	.05			
	ADJUSTMENTS TO PROGRAM	.50		1/30/2007	300,285
	ADJUSTMENTS TO PROGRAM	.51			
	ADJUSTMENTS TO PROGRAM	.52			
	ADJUSTMENTS TO PROGRAM	.53			
	ADJUSTMENTS TO PROGRAM	.54			
	SUBTOTAL	.99	19,780		-300,285
4	TOTAL INTERIM PAYMENTS		1,401,100		2,324,889
	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.				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	1/30/2007	5,984		
	ADJUSTMENTS TO PROVIDER .03				
	ADJUSTMENTS TO PROVIDER .04				
	ADJUSTMENTS TO PROVIDER .05				
	ADJUSTMENTS TO PROGRAM .50				
	ADJUSTMENTS TO PROGRAM .51				
	ADJUSTMENTS TO PROGRAM .52				
	ADJUSTMENTS TO PROGRAM .53				
	ADJUSTMENTS TO PROGRAM .54				
	ADJUSTMENTS TO PROGRAM .99				
	SUBTOTAL		5,984		NONE
4	TOTAL INTERIM PAYMENTS		723,900		NONE
	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.

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	509,169	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	273,263	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	848	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	782,432	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	782,432	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	782,432	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	10,340	
14	80% OF PART B COSTS		
15	SUBTOTAL	772,092	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	772,092	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	723,900	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	48,192	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	1,697,881
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	1,697,881
5	PRIMARY PAYER PAYMENTS	2,033
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	1,712,806
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	1,712,806
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	315,625
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,397,181
23	COINSURANCE	6,426
24	SUBTOTAL	1,390,755
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	33,369
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	33,369
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	29,452
26	SUBTOTAL	1,424,124
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	1,424,124
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,401,100
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	23,024
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

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)			
	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
	COST OF COVERED SERVICES			
24	PROSPECTIVE PAYMENT AMOUNT			
25	OTHER THAN OUTLIER PAYMENTS			
26	OUTLIER PAYMENTS			
27	PROGRAM CAPITAL PAYMENTS			
28	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
29	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
30	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
31	SUBTOTAL			
32	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
33	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30			
	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
34	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
35	EXCESS OF REASONABLE COST			
36	SUBTOTAL			
37	COINSURANCE			
38	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
38.01	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
38.02	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
38.03	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
39	UTILIZATION REVIEW			
40	SUBTOTAL (SEE INSTRUCTIONS)			
41	INPATIENT ROUTINE SERVICE COST			
42	MEDICARE INPATIENT ROUTINE CHARGES			
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
44	PAYMENT FOR SERVICES ON A CHARGE BASIS			
45	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
46	FOR PAYMENT OF PART A SERVICES			
47	RATIO OF LINE 43 TO 44			
48	TOTAL CUSTOMARY CHARGES			
49	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
50	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
51	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
52	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
53	OTHER ADJUSTMENTS (SPECIFY)			
54	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
55	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
56	SUBTOTAL			
57	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
58	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
59	TOTAL AMOUNT PAYABLE TO THE PROVIDER			
	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
	INTERIM PAYMENTS			
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
58	BALANCE DUE PROVIDER/PROGRAM			
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			
	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.			

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	8,421,803			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	3,279,269			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,128,350			
7	INVENTORY	168,961			
8	PREPAID EXPENSES	13,550			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	-745,255			
11	TOTAL CURRENT ASSETS	10,009,978			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	10,748,230			
14	LESS ACCUMULATED DEPRECIATION	-5,270,285			
14.01	LEASEHOLD IMPROVEMENTS				
15	LESS ACCUMULATED DEPRECIATION				
15.01	FIXED EQUIPMENT				
16	LESS ACCUMULATED DEPRECIATION				
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	5,477,945			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	2,478,336	407,487		
26	TOTAL OTHER ASSETS	2,478,336	407,487		
27	TOTAL ASSETS	17,966,259	407,487		

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		8,233,553		434,487
2 NET INCOME (LOSS)		3,454,109		
3 TOTAL		11,687,662		434,487
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 AMBULANCE GRANT			3,000	
6				
7				
8				
9				
10 TOTAL ADDITIONS				3,000
11 SUBTOTAL		11,687,662		437,487
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 MINIMUM PENSION LIAB 132,503				
14 HEALTH ACCESS WORKER GRAN			30,000	
15				
16				
17				
18 TOTAL DEDUCTIONS		132,503		30,000
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		11,555,159		407,487

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 AMBULANCE GRANT				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 MINIMUM PENSION LIAB				
14 HEALTH ACCESS WORKER GRAN				
15				
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
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
2 00 HOSPITAL	2,195,860		2,195,860
4 00 SUBPROVIDER			
5 00 SWING BED - SNF			
6 00 SWING BED - NF			
7 00 SKILLED NURSING FACILITY			
7 00 NURSING FACILITY			
8 01 ICF/MR			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,195,860		2,195,860
10 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
11 00 INTENSIVE CARE UNIT			
12 00 CORONARY CARE UNIT			
13 00 BURN INTENSIVE CARE UNIT			
15 00 SURGICAL INTENSIVE CARE UNIT			
16 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	2,195,860		2,195,860
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	4,308,210	26,743,919	31,052,129
18 00 ANCILLARY SERVICES			
18 50 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC-NORTH	217,024	1,418,751	1,635,775
18 51 RURAL HEALTH CLINIC 2-SOUTH	265,853	1,474,157	1,740,010
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES	172,432	1,142,132	1,314,564
21 00 CORF			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	7,159,379	30,778,959	37,938,338

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		14,647,368	
ADD (SPECIFY)			
27 00 BAD DEBT	2,272,764		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,272,764	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		16,920,132	

DESCRIPTION

1	TOTAL PATIENT REVENUES	37,938,338
2	LESS: ALLOWANCES AND DISCOUNTS ON	18,549,642
3	NET PATIENT REVENUES	19,388,696
4	LESS: TOTAL OPERATING EXPENSES	16,920,132
5	NET INCOME FROM SERVICE TO PATIENT OTHER INCOME	2,468,564
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	564,056
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	
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	2,712
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	MISC REVENUE	-770
24.01	AMBULANCE SUBSIDY	278,132
24.02	RENTAL INCOME	19,360
24.03	NET ASSETS RELEASED FROM REST	30,000
24.04	INCENTIVE PAYMENTS	58,077
24.05	PATIENT MONEY	31,575
24.06	MEDICAL RECORDS	403
24.07	MEDICAL DIRECTOR	2,000
24.08		
24.09		
24.10		
24.11		
25	TOTAL OTHER INCOME	985,545
26	TOTAL	3,454,109
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	3,454,109

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	469,491		469,491	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER				
5 VISITING NURSE				
6 OTHER NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
10 OTHER FACILITY HEALTH CARE STAFF COSTS	388,028		388,028	
11 SUBTOTAL (SUM OF LINES 1-9)	857,519		857,519	
12 COSTS UNDER AGREEMENT				
13 PHYSICIAN SERVICES UNDER AGREEMENT				
14 PHYSICIAN SUPERVISION UNDER AGREEMENT				
15 OTHER COSTS UNDER AGREEMENT				
16 SUBTOTAL (SUM OF LINES 11-13)				
17 OTHER HEALTH CARE COSTS				
18 MEDICAL SUPPLIES		46,247	46,247	
19 TRANSPORTATION (HEALTH CARE STAFF)				
20 DEPRECIATION-MEDICAL EQUIPMENT				
21 PROFESSIONAL LIABILITY INSURANCE				
22 OTHER HEALTH CARE COSTS		78,541	78,541	17,812
23 ALLOWABLE GME COSTS				
24 SUBTOTAL (SUM OF LINES 15-20)		124,788	124,788	17,812
25 TOTAL COST OF HEALTH CARE SERVICES	857,519	124,788	982,307	17,812
26 (SUM OF LINES 10, 14, AND 21)				
27 COSTS OTHER THAN RHC/FQHC SERVICES				
28 PHARMACY				
29 DENTAL				
30 OPTOMETRY				
31 ALL OTHER NONREIMBURSABLE COSTS				
32 NONALLOWABLE GME COSTS				
33 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
34 FACILITY OVERHEAD				
35 FACILITY COSTS				
36 ADMINISTRATIVE COSTS				
37 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	857,519	124,788	982,307	17,812
38 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7	
39 FACILITY HEALTH CARE STAFF COSTS				
40 PHYSICIAN	469,491		469,491	
41 PHYSICIAN ASSISTANT				
42 NURSE PRACTITIONER				
43 VISITING NURSE				
44 OTHER NURSE				
45 CLINICAL PSYCHOLOGIST				
46 CLINICAL SOCIAL WORKER				
47 LABORATORY TECHNICIAN				
48 OTHER FACILITY HEALTH CARE STAFF COSTS	388,028		388,028	
49 SUBTOTAL (SUM OF LINES 1-9)	857,519		857,519	
50 COSTS UNDER AGREEMENT				
51 PHYSICIAN SERVICES UNDER AGREEMENT				
52 PHYSICIAN SUPERVISION UNDER AGREEMENT				
53 OTHER COSTS UNDER AGREEMENT				
54 SUBTOTAL (SUM OF LINES 11-13)				
55 OTHER HEALTH CARE COSTS				
56 MEDICAL SUPPLIES	46,247		46,247	
57 TRANSPORTATION (HEALTH CARE STAFF)				
58 DEPRECIATION-MEDICAL EQUIPMENT				
59 PROFESSIONAL LIABILITY INSURANCE				
60 OTHER HEALTH CARE COSTS	96,353	-109	96,244	
61 ALLOWABLE GME COSTS				
62 SUBTOTAL (SUM OF LINES 15-20)	142,600	-109	142,491	
63 TOTAL COST OF HEALTH CARE SERVICES	1,000,119	-109	1,000,010	
64 (SUM OF LINES 10, 14, AND 21)				
65 COSTS OTHER THAN RHC/FQHC SERVICES				
66 PHARMACY				
67 DENTAL				
68 OPTOMETRY				
69 ALL OTHER NONREIMBURSABLE COSTS				
70 NONALLOWABLE GME COSTS				
71 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
72 FACILITY OVERHEAD				
73 FACILITY COSTS				
74 ADMINISTRATIVE COSTS				
75 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	1,000,119	-109	1,000,010	
76 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)				

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	351,221		351,221	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER				
5 VISITING NURSE				
6 OTHER NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
9 OTHER FACILITY HEALTH CARE STAFF COSTS	466,269		466,269	
10 SUBTOTAL (SUM OF LINES 1-9)	817,490		817,490	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)				
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES		58,290	58,290	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS		60,721	60,721	20,038
21 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		119,011	119,011	20,038
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	817,490	119,011	936,501	20,038
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY				
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS				
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 FACILITY OVERHEAD				
30 FACILITY COSTS				
31 ADMINISTRATIVE COSTS				
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	817,490	119,011	936,501	20,038
	RECLASSIFIED		NET EXPENSES	
	TRIAL		FOR	
	BALANCE	ADJUSTMENTS	ALLOCATION	
	5	6	7	
1 FACILITY HEALTH CARE STAFF COSTS				
2 PHYSICIAN	351,221		351,221	
3 PHYSICIAN ASSISTANT				
4 NURSE PRACTITIONER				
5 VISITING NURSE				
6 OTHER NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 LABORATORY TECHNICIAN				
9 OTHER FACILITY HEALTH CARE STAFF COSTS	466,269		466,269	
10 SUBTOTAL (SUM OF LINES 1-9)	817,490		817,490	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)				
15 OTHER HEALTH CARE COSTS				
16 MEDICAL SUPPLIES	58,290		58,290	
17 TRANSPORTATION (HEALTH CARE STAFF)				
18 DEPRECIATION-MEDICAL EQUIPMENT				
19 PROFESSIONAL LIABILITY INSURANCE				
20 OTHER HEALTH CARE COSTS	80,759	-109	80,650	
21 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)	139,049	-109	138,940	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	956,539	-109	956,430	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
24 PHARMACY				
25 DENTAL				
26 OPTOMETRY				
27 ALL OTHER NONREIMBURSABLE COSTS				
28 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
29 FACILITY OVERHEAD				
30 FACILITY COSTS				
31 ADMINISTRATIVE COSTS				
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)				
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	956,539	-109	956,430	

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	3.00	4,200	12,600
2	PHYSICIAN ASSISTANTS		2,100	
3	NURSE PRACTITIONERS	.63	2,100	1,323
4	SUBTOTAL (SUM OF LINES 1-3)	3.63		13,923
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	3.63	13,405	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)		1,000,010	
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)		1,000,010	
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)		1.000000	
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)		612,519	
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)		612,519	
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16		612,519	
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)		612,519	
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)		1,612,529	
			GREATER OF COL. 2 OR COL. 4	5
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)			13,923
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)			13,923
9	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.

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007
I 15-1307 I FROM 7/ 1/2006 I WORKSHEET M-2
I COMPONENT NO: I TO 6/30/2007 I
I 15-3994 I I

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	2.30	4,200	9,660
2	PHYSICIAN ASSISTANTS		2,100	
3	NURSE PRACTITIONERS	1.00	3,880	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	3.30	13,356	11,760
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	3.30	13,356	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	956,430		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	956,430		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	609,196		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	609,196		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	609,196		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	609,196		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,565,626		
		GREATER OF COL. 2 OR COL. 4 5		
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	13,356		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	13,356		
9	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 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	1,565,626
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,565,626
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	13,356
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	13,356
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	117.22

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)	70.78	72.76
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	117.22	117.22
10 CALCULATION OF SETTLEMENT		
PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	4,158	
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	487,401	
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)*		487,401
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		48,042
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		439,359
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		351,487
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		351,487
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		6,946
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)		358,433
25 INTERIM PAYMENTS		347,129
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		11,304
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(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 AMOUNT
 MM/DD/YYYY 1 2

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.				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	12/31/2007		9,638
	ADJUSTMENTS TO PROVIDER	.02			
	ADJUSTMENTS TO PROVIDER	.03			
	ADJUSTMENTS TO PROVIDER	.04			
	ADJUSTMENTS TO PROVIDER	.05			
	ADJUSTMENTS TO PROGRAM	.50			
	ADJUSTMENTS TO PROGRAM	.51			
	ADJUSTMENTS TO PROGRAM	.52			
	ADJUSTMENTS TO PROGRAM	.53			
	ADJUSTMENTS TO PROGRAM	.54			
	SUBTOTAL	.99			9,638
4	TOTAL INTERIM PAYMENTS				246,933
	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
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.

RHC 2

DESCRIPTION

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

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.			335,147
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)			NONE
	ADJUSTMENTS TO PROVIDER	.01	1/30/2007	11,982
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	ADJUSTMENTS TO PROGRAM	.99		
	SUBTOTAL			11,982
4	TOTAL INTERIM PAYMENTS			347,129
	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.