

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

WORKSHEET S  
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION	I	15-1309	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:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/26/2007 TIME 15:14

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 CLAY HOSPITAL 15-1309  
 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.

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 ECR ENCRYPTION INFORMATION  
 DATE: 11/26/2007 TIME 15:14

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

-----  
 TITLE

-----  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX	
	1	A 2	B 3		4	
1	HOSPITAL	0	357,684	529,625	0	
3	SWING BED - SNF	0	164,163	0	0	
100	TOTAL	0	521,847	529,625	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: 1206 EAST NATIONAL AVENUE P.O. BOX:  
 1.01 CITY: BRAZIL STATE: IN ZIP CODE: 47834- COUNTY: CLAY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;		PROVIDER NO.		NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N)		
COMPONENT 0	COMPONENT NAME 1	2	2.01	3	4	V XVIII	5	XIX
02.00	HOSPITAL	15-1309		8/ 8/2001	N	0	N	N
04.00	SWING BED - SNF	15-2309		8/ 8/2001	N	0	N	N

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

TYPE OF HOSPITAL/SUBPROVIDER  
 19 HOSPITAL  
 20 SUBPROVIDER

OTHER INFORMATION  
 21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.  
 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 N 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. N  
 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?  
 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.  
 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N  
 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)  
 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)  
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.  
 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0  
 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /  
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /  
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 8/ 8/2001

	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 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

	V	XVIII	XIX
36	1	2	3
36.01	N	N	N
37	N	N	N
37.01	N	N	N

TITLE XIX INPATIENT SERVICES  
 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? 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?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)  
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

	PART A 1	PART B 2	OUTPATIENT ASC 3	OUTPATIENT RADIOLOGY 4	OUTPATIENT DIAGNOSTIC 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: 52,826 PAID LOSSES: 0 AND/OR SELF INSURANCE: 0					
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.					N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.					N

	DATE 0	Y OR N 1	LIMIT 2	Y OR N 3	FEES 4
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.	7/ 1/2006	N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N  
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N  
 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0  
 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N  
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N  
 60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

HOSPITAL AND HOSPITAL HEALTH CARE  
 COMPLEX STATISTICAL DATA

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	1	25	9,125	58,824.00	3	1,712	5
2 HMO							167
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						1,105	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,125				2,817	167
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	25	9,125				2,817	167
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							
25 TOTAL	25						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED	I/P DAYS / OBSERVATION BEDS / NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	TRIPS / TOTAL ADMITTED	OBSERVATION BEDS / NOT ADMITTED	INTERNS & RES. FTES / TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			2,451				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,105				
4 ADULTS & PED-SB NF			85				
5 TOTAL ADULTS AND PEDS			3,641				
6 INTENSIVE CARE UNIT							
7 CORONARY CARE UNIT							
8 BURN INTENSIVE CARE UNIT							
9 SURGICAL INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			3,641				
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							
25 TOTAL							
26 OBSERVATION BED DAYS			1,037	24	1,013		
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES / NET	--- FULL TIME EMPLOYEES / ON PAYROLL	EQUIV NONPAID WORKERS /	DISCHARGES / TITLE V	DISCHARGES / TITLE XVIII	DISCHARGES / TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					487	60	923
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		135.83			487	60	923
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							

COMPONENT	I & R FTES NET	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV --- NONPAID WORKERS	----- TITLE V	DISCHARGES TITLE XVIII	----- TITLE XIX	TOTAL ALL PATIENTS
25 TOTAL	9	10	11	12	13	14	15
26 OBSERVATION BED DAYS		135.83					
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
		1	2	3	4	5
1	0100 GENERAL SERVICE COST CNTR					
2	0200 OLD CAP REL COSTS-BLDG & FIXT					
3	0300 OLD CAP REL COSTS-MVBLE EQUIP					
4	0400 NEW CAP REL COSTS-BLDG & FIXT		626,868	626,868	-309,274	317,594
4.01	0401 NEW CAP REL COSTS-MOB BLDG		763,691	763,691	284,070	1,047,761
5	0500 EMPLOYEE BENEFITS	24,306	325,474	325,474		325,474
6	0600 ADMINISTRATIVE & GENERAL	1,179,689	1,460,421	1,484,727	-1,636	1,483,091
7	0700 MAINTENANCE & REPAIRS		953,183	2,132,872	26,562	2,159,434
8	0800 OPERATION OF PLANT	276,578		776,372		776,372
9	0900 LAUNDRY & LINEN SERVICE		499,794	81,186		81,186
10	1000 HOUSEKEEPING	201,882	81,186	254,084		254,084
11	1100 DIETARY	245,548	52,202	345,681		254,084
12	1200 CAFETERIA		100,133		-171,058	174,623
13	1300 MAINTENANCE OF PERSONNEL				170,974	170,974
14	1400 NURSING ADMINISTRATION	329,168		370,893	14,612	385,505
15	1500 CENTRAL SERVICES & SUPPLY		41,725	60,736	67,715	128,451
16	1600 PHARMACY		60,736	365,926		365,926
17	1700 MEDICAL RECORDS & LIBRARY	164,833	22,920	187,753		187,753
18	1800 SOCIAL SERVICE					
20	2000 NONPHYSICIAN ANESTHETISTS					
21	2100 NURSING SCHOOL					
22	2200 I&R SERVICES-SALARY & FRINGES APPRVD					
23	2300 I&R SERVICES-OTHER PRGM COSTS APPRVD					
24	2400 PARAMED ED PRGM					
25	2500 INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,020,439	141,872	1,162,311	-28,019	1,134,292
26	2600 INTENSIVE CARE UNIT					
27	2700 CORONARY CARE UNIT					
28	2800 BURN INTENSIVE CARE UNIT					
29	2900 SURGICAL INTENSIVE CARE UNIT					
31	3100 SUBPROVIDER					
33	3300 NURSERY					
34	3400 SKILLED NURSING FACILITY					
35	3500 NURSING FACILITY					
35.01	3510 ICF/MR					
36	3600 OTHER LONG TERM CARE					
37	3700 ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	409,126	676,706	1,085,832	-471,305	614,527
38	3800 RECOVERY ROOM					
39	3900 DELIVERY ROOM & LABOR ROOM					
40	4000 ANESTHESIOLOGY	178,567	152,630	331,197		331,197
41	4100 RADIOLOGY-DIAGNOSTIC	543,197	797,987	1,341,184		1,341,184
42	4200 RADIOLOGY-THERAPEUTIC					
43	4300 RADIOISOTOPE					
44	4400 LABORATORY	328,682	857,392	1,186,074		1,186,074
45	4500 PBP CLINICAL LAB SERVICES-PRGM ONLY					
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS					
47	4700 BLOOD STORING, PROCESSING & TRANS.					
48	4800 INTRAVENOUS THERAPY					
49	4900 RESPIRATORY THERAPY	108,844	43,457	152,301		152,301
50	5000 PHYSICAL THERAPY		393,573	393,573		393,573
51	5100 OCCUPATIONAL THERAPY					
52	5200 SPEECH PATHOLOGY		3,789	3,789		3,789
53	5300 ELECTROCARDIOLOGY	108,578	29,871	138,449		138,449
54	5400 ELECTROENCEPHALOGRAPHY					
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		256,691	256,691	466,176	722,867
56	5600 DRUGS CHARGED TO PATIENTS		608,604	608,604		608,604
57	5700 RENAL DIALYSIS					
58	5800 ASC (NON-DISTINCT PART)					
60	6000 OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC					
61	6100 EMERGENCY	591,505	509,879	1,101,384	-34,567	1,066,817
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
64	6400 OTHER REIMBURS COST CNTRS					
65	6500 HOME PROGRAM DIALYSIS					
66	6600 AMBULANCE SERVICES					
66	6600 DURABLE MEDICAL EQUIP-RENTED					
67	6700 DURABLE MEDICAL EQUIP-SOLD					
69	6900 CORF					
70	7000 I&R SERVICES-NOT APPRVD PRGM					
71	7100 HOME HEALTH AGENCY					
82	8200 SPEC PURPOSE COST CENTERS					
82	8200 LUNG ACQUISITION					
83	8300 KIDNEY ACQUISITION					
84	8400 LIVER ACQUISITION					
85	8500 HEART ACQUISITION					
85.01	8510 PANCREAS ACQUISITION					
86	8600 OTHER ORGAN ACQUISITION					
88	8800 INTEREST EXPENSE					
89	8900 UTILIZATION REVIEW-SNF					
90	9000 OTHER CAPITAL RELATED COSTS					
92	9200 AMBULATORY SURGICAL CENTER (D.P.)					
93	9300 HOSPICE					
95	SUBTOTALS	5,710,942	9,826,710	15,537,652	14,250	15,551,902
96	9600 NONREIMBURS COST CENTERS					
97	9700 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 RESEARCH					
98.01	9801 PHYSICIANS' PRIVATE OFFICES	57	15,854	15,911		15,911
98.02	9802 CLAY COUNTY CLINIC	179,425	125,575	305,000	-1,956	303,044
98.03	9803 MISSION SERVICES	1,518	3,983	5,501	7,088	12,589
98.04	9804 PUBLIC RELATIONS	41,574	86,074	127,648	-19,382	108,266
99	9900 NONPAID WORKERS					
100	7950 OTHER NONREIMBURSABLE COST CENTERS					
101	TOTAL	5,933,516	10,058,196	15,991,712	-0-	15,991,712

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET A  
 I I TO 6/30/2007 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
1	0100 GENERAL SERVICE COST CNTR		
2	0200 OLD CAP REL COSTS-BLDG & FIXT		
3	0300 OLD CAP REL COSTS-MVBLE EQUIP		
4	0400 NEW CAP REL COSTS-BLDG & FIXT	93,357	410,951
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP	-271,969	775,792
5	0500 NEW CAP REL COSTS-MOB BLDG		325,474
6	0600 EMPLOYEE BENEFITS	286,156	1,769,247
7	0700 ADMINISTRATIVE & GENERAL	954,272	3,113,706
8	0800 MAINTENANCE & REPAIRS		
9	0900 OPERATION OF PLANT		776,372
10	1000 LAUNDRY & LINEN SERVICE		81,186
11	1100 HOUSEKEEPING		254,084
12	1200 DIETARY		174,623
13	1300 CAFETERIA	-37,351	133,623
14	1400 MAINTENANCE OF PERSONNEL		
15	1500 NURSING ADMINISTRATION		385,505
16	1600 CENTRAL SERVICES & SUPPLY		128,451
17	1700 PHARMACY		365,926
18	1800 MEDICAL RECORDS & LIBRARY	-4,602	183,151
20	2000 SOCIAL SERVICE		
21	2100 NONPHYSICIAN ANESTHETISTS		
22	2200 NURSING SCHOOL		
23	2300 I&R SERVICES-SALARY & FRINGES APPRVD		
24	2400 I&R SERVICES-OTHER PRGM COSTS APPRVD		
25	2500 PARAMED ED PRGM		
26	2600 INPAT ROUTINE SRVC CNTRS		1,134,292
27	2700 ADULTS & PEDIATRICS		
28	2800 INTENSIVE CARE UNIT		
29	2900 CORONARY CARE UNIT		
30	3000 BURN INTENSIVE CARE UNIT		
31	3100 SURGICAL INTENSIVE CARE UNIT		
32	3200 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		614,527
39	3900 RECOVERY ROOM		
40	4000 DELIVERY ROOM & LABOR ROOM		
41	4100 ANESTHESIOLOGY	-331,197	
42	4200 RADIOLOGY-DIAGNOSTIC		1,341,184
43	4300 RADIOLOGY-THERAPEUTIC		
44	4400 RADIOISOTOPE		
45	4500 LABORATORY		1,186,074
46	4600 PBP CLINICAL LAB SERVICES-PRGM ONLY		
47	4700 WHOLE BLOOD & PACKED RED BLOOD CELLS		
48	4800 BLOOD STORING, PROCESSING & TRANS.		
49	4900 INTRAVENOUS THERAPY		
50	5000 RESPIRATORY THERAPY		152,301
51	5100 PHYSICAL THERAPY		393,573
52	5200 OCCUPATIONAL THERAPY		
53	5300 SPEECH PATHOLOGY		3,789
54	5400 ELECTROCARDIOLOGY		138,449
55	5500 ELECTROENCEPHALOGRAPHY		
56	5600 MEDICAL SUPPLIES CHARGED TO PATIENTS		722,867
57	5700 DRUGS CHARGED TO PATIENTS	-12,030	596,574
58	5800 RENAL DIALYSIS		
60	6000 ASC (NON-DISTINCT PART)		
61	6100 OUTPAT SERVICE COST CNTRS		
62	6200 CLINIC		
63	6300 EMERGENCY		1,066,817
64	6400 OBSERVATION BEDS (NON-DISTINCT PART)		
65	6500 OTHER REIMBURS COST CNTRS		
66	6600 HOME PROGRAM DIALYSIS		
67	6700 AMBULANCE SERVICES		
68	6800 DURABLE MEDICAL EQUIP-RENTED		
69	6900 DURABLE MEDICAL EQUIP-SOLD		
70	7000 CORF		
71	7100 I&R SERVICES-NOT APPRVD PRGM		
82	8200 HOME HEALTH AGENCY		
83	8300 SPEC PURPOSE COST CENTERS		
84	8400 LUNG ACQUISITION		
85	8500 KIDNEY ACQUISITION		
86	8600 LIVER ACQUISITION		
87	8700 HEART ACQUISITION		
88	8800 PANCREAS ACQUISITION		
89	8900 OTHER ORGAN ACQUISITION		
90	9000 INTEREST EXPENSE		-0-
91	9100 UTILIZATION REVIEW-SNF		-0-
92	9200 OTHER CAPITAL RELATED COSTS		-0-
93	9300 AMBULATORY SURGICAL CENTER (D.P.)		
94	9400 HOSPICE		
95	9500 SUBTOTALS	676,636	16,228,538
96	9600 NONREIMBURS COST CENTERS		
97	9700 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 RESEARCH		
98.01	9801 PHYSICIANS' PRIVATE OFFICES		15,911
98.02	9802 PHYSICIANS' PRIVATE OFFICES		303,044
98.03	9803 CLAY COUNTY CLINIC		12,589
98.04	9804 MISSION SERVICES		108,266
99	9900 PUBLIC RELATIONS		
100	9900 NONPAID WORKERS		
101	7950 OTHER NONREIMBURSABLE COST CENTERS		
102	TOTAL	676,636	16,668,348

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	
4.01	NEW CAP REL COSTS-MOB BLDG	0401	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
13	MAINTENANCE OF PERSONNEL	1300	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
21	NURSING SCHOOL	2100	
22	I&R SERVICES-SALARY & FRINGES APPRVD	2200	
23	I&R SERVICES-OTHER PRGM COSTS APPRVD	2300	
24	PARAMED ED PRGM	2400	
INPAT ROUTINE SRVC C			
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
27	CORONARY CARE UNIT	2700	
28	BURN INTENSIVE CARE UNIT	2800	
29	SURGICAL INTENSIVE CARE UNIT	2900	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
35.01	ICF/MR	3510	
36	OTHER LONG TERM CARE	3600	
ANCILLARY SRVC COST			
37	OPERATING ROOM	3700	
38	RECOVERY ROOM	3800	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
42	RADIOLOGY-THERAPEUTIC	4200	
43	RADIOISOTOPE	4300	
44	LABORATORY	4400	
45	PBP CLINICAL LAB SERVICES-PRGM ONLY	4500	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
48	INTRAVENOUS THERAPY	4800	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
57	RENAL DIALYSIS	5700	
58	ASC (NON-DISTINCT PART)	5800	
OUTPAT SERVICE COST			
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
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	
98.01	PHYSICIANS' PRIVATE OFFICES	9801	PHYSICIANS' PRIVATE OFFICES
98.02	CLAY COUNTY CLINIC	9802	PHYSICIANS' PRIVATE OFFICES
98.03	MISSION SERVICES	9803	PHYSICIANS' PRIVATE OFFICES
98.04	PUBLIC RELATIONS	9804	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO:  
151309

EXPLANATION OF RECLASSIFICATION	INCREASE				
	CODE (1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA	A	CAFETERIA	12	121,448	49,526
2 INTEREST	B	ADMINISTRATIVE & GENERAL	6		27,160
3		NEW CAP REL COSTS-BLDG & FIXT	3		78,428
4		NEW CAP REL COSTS-MVBLE EQUIP	4		266,994
5 ROUTINE, OR, AND ER BILL SUPP	C	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		471,305
6		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		34,567
7		MEDICAL SUPPLIES CHARGED TO PATIENTS	55		28,019
8 CLINIC CAPITAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4		1,956
9 INVENTORY ADJUSTMENT	E	CENTRAL SERVICES & SUPPLY	15		67,715
10 PROPERTY INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		4,442
11		NEW CAP REL COSTS-MVBLE EQUIP	4		15,120
12 HEALTH ACCESS	H	MISSION SERVICES	98.03	5,452	
13 BENEFITS	I	MISSION SERVICES	98.03		1,636
14 NURSING EDUCATION	J	NURSING ADMINISTRATION	14	20,787	
15 PUBLIC RELATIONS	K	PUBLIC RELATIONS	98.04		1,405
16					
17					
36 TOTAL RECLASSIFICATIONS				147,687	1,048,273

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

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER	DECREASE			A-7 REF 10	
		LINE NO	SALARY	OTHER		
	1	6	7	8	9	
1 CAFETERIA	A	DIETARY	11	121,448	49,526	
2 INTEREST	B	NEW CAP REL COSTS-BLDG & FIXT	3		27,160	11
3		NEW CAP REL COSTS-BLDG & FIXT	3		345,422	11
4						11
5 ROUTINE, OR, AND ER BILL SUPP	C	OPERATING ROOM	37		471,305	
6		EMERGENCY	61		34,567	
7		ADULTS & PEDIATRICS	25		28,019	
8 CLINIC CAPITAL	D	CLAY COUNTY CLINIC	98.02		1,956	11
9 INVENTORY ADJUSTMENT	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		67,715	
10 PROPERTY INSURANCE	G	NEW CAP REL COSTS-BLDG & FIXT	3		19,562	11
11						11
12 HEALTH ACCESS	H	NURSING ADMINISTRATION	14	5,452		
13 BENEFITS	I	EMPLOYEE BENEFITS	5		1,636	
14 NURSING EDUCATION	J	PUBLIC RELATIONS	98.04	20,787		
15 PUBLIC RELATIONS	K	ADMINISTRATIVE & GENERAL	6		598	
16		NURSING ADMINISTRATION	14		723	
17		DIETARY	11		84	
36 TOTAL RECLASSIFICATIONS				147,687	1,048,273	

(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

RECLASS CODE: A  
 EXPLANATION : CAFETERIA

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	170,974
TOTAL RECLASSIFICATIONS FOR CODE A			170,974

DECREASE			
COST CENTER	LINE	AMOUNT	
DIETARY	11	170,974	
		170,974	

RECLASS CODE: B  
 EXPLANATION : INTEREST

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	27,160
2.00	NEW CAP REL COSTS-BLDG & FIXT	3	78,428
3.00	NEW CAP REL COSTS-MVBLE EQUIP	4	266,994
TOTAL RECLASSIFICATIONS FOR CODE B			372,582

DECREASE			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	27,160	
NEW CAP REL COSTS-BLDG & FIXT	3	345,422	
		0	
		372,582	

RECLASS CODE: C  
 EXPLANATION : ROUTINE, OR, AND ER BILL SUPP

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	471,305
2.00	MEDICAL SUPPLIES CHARGED TO PA	55	34,567
3.00	MEDICAL SUPPLIES CHARGED TO PA	55	28,019
TOTAL RECLASSIFICATIONS FOR CODE C			533,891

DECREASE			
COST CENTER	LINE	AMOUNT	
OPERATING ROOM	37	471,305	
EMERGENCY	61	34,567	
ADULTS & PEDIATRICS	25	28,019	
		533,891	

RECLASS CODE: D  
 EXPLANATION : CLINIC CAPITAL

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	1,956
TOTAL RECLASSIFICATIONS FOR CODE D			1,956

DECREASE			
COST CENTER	LINE	AMOUNT	
CLAY COUNTY CLINIC	98.02	1,956	
		1,956	

RECLASS CODE: E  
 EXPLANATION : INVENTORY ADJUSTMENT

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	CENTRAL SERVICES & SUPPLY	15	67,715
TOTAL RECLASSIFICATIONS FOR CODE E			67,715

DECREASE			
COST CENTER	LINE	AMOUNT	
MEDICAL SUPPLIES CHARGED TO PA	55	67,715	
		67,715	

RECLASS CODE: G  
 EXPLANATION : PROPERTY INSURANCE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	4,442
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	15,120
TOTAL RECLASSIFICATIONS FOR CODE G			19,562

DECREASE			
COST CENTER	LINE	AMOUNT	
NEW CAP REL COSTS-BLDG & FIXT	3	19,562	
		0	
		19,562	

RECLASS CODE: H  
 EXPLANATION : HEALTH ACCESS

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MISSION SERVICES	98.03	5,452
TOTAL RECLASSIFICATIONS FOR CODE H			5,452

DECREASE			
COST CENTER	LINE	AMOUNT	
NURSING ADMINISTRATION	14	5,452	
		5,452	

RECLASS CODE: I  
 EXPLANATION : BENEFITS

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MISSION SERVICES	98.03	1,636
TOTAL RECLASSIFICATIONS FOR CODE I			1,636

DECREASE			
COST CENTER	LINE	AMOUNT	
EMPLOYEE BENEFITS	5	1,636	
		1,636	

RECLASS CODE: J  
 EXPLANATION : NURSING EDUCATION

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NURSING ADMINISTRATION	14	20,787
TOTAL RECLASSIFICATIONS FOR CODE J			20,787

DECREASE			
COST CENTER	LINE	AMOUNT	
PUBLIC RELATIONS	98.04	20,787	
		20,787	

RECLASS CODE: K  
 EXPLANATION : PUBLIC RELATIONS

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	PUBLIC RELATIONS	98.04	1,405

DECREASE			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	598	

RECLASSIFICATIONS

RECLASS CODE: K  
 EXPLANATION : PUBLIC RELATIONS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
2.00		0	14	NURSING ADMINISTRATION	723
3.00		0	11	DIETARY	84
TOTAL RECLASSIFICATIONS FOR CODE K		1,405			1,405

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
	BALANCES		DONATION		AND		BALANCE
	1	2	3	4	5	6	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	PURCHASES	ACQUISITIONS	TOTAL	DISPOSALS	ENDING	FULLY
	BALANCES		DONATION		AND		BALANCE
	1	2	3	4	5	6	7
1 LAND	2,500					2,500	
2 LAND IMPROVEMENTS	317,947					317,947	
3 BUILDINGS & FIXTURE	8,838,481	93,863		93,863		8,932,344	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	2,349,084					2,349,084	
6 MOVABLE EQUIPMENT	6,314,473	245,088		245,088		6,559,561	
7 SUBTOTAL	17,822,485	338,951		338,951		18,161,436	
8 RECONCILING ITEMS							
9 TOTAL	17,822,485	338,951		338,951		18,161,436	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS 1	CAPITIALIZED LEASES 2	GROSS ASSETS FOR RATIO 3	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
1	OLD CAP REL COSTS-BL							8
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	9,252,791		9,252,791				
4	NEW CAP REL COSTS-MV	8,908,645		8,908,645				
4 01	NEW CAP REL COSTS-MO							
5	TOTAL	18,161,436		18,161,436				

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	795,162		-384,211				410,951
4	NEW CAP REL COSTS-MV	746,833		28,959				775,792
4 01	NEW CAP REL COSTS-MO	325,474						325,474
5	TOTAL	1,867,469		-355,252				1,512,217

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 14	TOTAL (1) 15
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13		
1	OLD CAP REL COSTS-BL							
2	OLD CAP REL COSTS-MV							
3	NEW CAP REL COSTS-BL	626,868						626,868
4	NEW CAP REL COSTS-MV	763,691						763,691
4 01	NEW CAP REL COSTS-MO	325,474						325,474
5	TOTAL	1,716,033						1,716,033

\* 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 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
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	-74,937	NEW CAP REL COSTS-BLDG &		3	11
4 INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-255,111	NEW CAP REL COSTS-MVBLE E		4	11
5 INVESTMENT INCOME-OTHER	B	-25,951	ADMINISTRATIVE & GENERAL		6	
6 TRADE, QUANTITY AND TIME DISCOUNTS						
7 REFUNDS AND REBATES OF EXPENSES						
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS						
9 TELEPHONE SERVICES	A	-9,000	ADMINISTRATIVE & GENERAL		6	
10 TELEVISION AND RADIO SERVICE	A	-2,079	ADMINISTRATIVE & GENERAL		6	
11 PARKING LOT						
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-142,479				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	1,446,177				
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-37,351	CAFETERIA		12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS						
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-12,030	DRUGS CHARGED TO PATIENTS		56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-4,602	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 INCOME	B	-6,898	ADMINISTRATIVE & GENERAL		6	
38 MISC NON-REIMBURSABLE	A	-3,424	ADMINISTRATIVE & GENERAL		6	
39						
40 PHYSICIAN RECRUITMENT	A	-117	ADMINISTRATIVE & GENERAL		6	
41						
42						
43 NON REIMBURSABLE ANESTHESIOLOGY EXPE	A	-188,718	ANESTHESIOLOGY		40	
44						
45						
46						
47						
48 FUNDRAISING	A	-6,844	ADMINISTRATIVE & GENERAL		6	
49						
49.01						
50 TOTAL (SUM OF LINES 1 THRU 49)		676,636				

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & HOME OFFICE	193,238	19,992	173,246	9
2	6	ADMINISTRATIVE & GENERAL HOME OFFICE	1,137,336	127,524	1,009,812	9
3	5	EMPLOYEE BENEFITS ST. VINCENT HOSPITAL - IN	105,138	105,138		
4	6	ADMINISTRATIVE & GENERAL ST. VINCENT HOSPITAL - IN	563,072	563,072		
4.02	5	EMPLOYEE BENEFITS ASCENSION -CHARGEBACK	64,788	64,788		
4.03	3	NEW CAP REL COSTS-BLDG & ASCENSION - CHARGEBACK	392,144	392,144		9
4.04	6	ADMINISTRATIVE & GENERAL ASCENSION - CHARGEBACK	202,306	202,306		
4.05	3	NEW CAP REL COSTS-BLDG & ASCENSION - INTEREST	73,476	78,428	-4,952	9
4.06	6	ADMINISTRATIVE & GENERAL ASCENSION - INTEREST	25,445	27,160	-1,715	9
4.08	6	ADMINISTRATIVE & GENERAL ASCENSION - MAINTENANCE	292,102	291,614	488	
4.09	41	RADIOLOGY-DIAGNOSTIC ST. VINCENT HOSPITAL - IN				
4.10	98	2 CLAY COUNTY CLINIC ST. VINCENT HOSPITAL - IN	8,645	8,645		
4.11	3	NEW CAP REL COSTS-BLDG & ST. VINCENT HOSPITAL - IN	7,385	7,385		9
4.12	4	NEW CAP REL COSTS-MVBLE E ASCENSION - INTEREST	250,136	266,994	-16,858	9
4.13	5	EMPLOYEE BENEFITS SELF INSURANCE	976,331	690,175	286,156	
4.14	16	PHARMACY ST. VINCENT HOSPITAL - IN	-16,464	-16,464		
4.15						
4.16						
4.17						
5		TOTALS	4,275,078	2,828,901	1,446,177	

\* 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	ST. VINCENT HEALTH	100.00	ST. VINCENT HEALTH	100.00	ADMINISTRATION
2	B	ST. VINCENT HOSPITAL	100.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL
3	G	ASCENSION	100.00	ASCENSION	100.00	ADMINISTRATION
4			0.00		0.00	
5			0.00		0.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I CMS-2552-96(9/1996)  
 I 15-1309 I FROM 7/ 1/2006 I PREPARED 11/26/2007  
 I I TO 6/30/2007 I WORKSHEET A-8-2  
 I GROUP 1

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 44	LABORATORY	23,715		23,715				
2 61	EMERGENCY	381,241		381,241				
3 40	ANESTHESIA	142,479	142,479					
4								
5								
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	547,435	142,479	404,956				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET A-8-2  
 I I TO 6/30/2007 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF COL 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COL 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1 44	LABORATORY							
2 61	EMERGENCY							
3 40	ANESTHESIA							142,479
4								
5								
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							142,479

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

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	452
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	33
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9	TOTAL HOURS WORKED	1180.00	2553.00	3175.00	2896.00
10	AHSEA (SEE INSTRUCTIONS)	82.27	65.81	49.39	32.91
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.91	32.91	24.70	
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	97,079
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	168,013
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	156,813
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS )	421,905
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	95,307
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	517,212

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES' (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	517,212

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

STANDARD TRAVEL ALLOWANCE		
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	14,875
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	815
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	15,690
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	15,690
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN 8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	15,690
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PHYSICAL THERAPY

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	517,212
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	15,690
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	532,902
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	384,738
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	384,738
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	384,738
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

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

I PROVIDER NO:  
I 15-1309  
I

IN LIEU OF FORM CMS-2552-96(12/1999)  
I PERIOD: I PREPARED 11/26/2007  
I FROM 7/ 1/2006 I WORKSHEET A-8-4  
I TO 6/30/2007 I PARTS I - VII

PHYSICAL THERAPY

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

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

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

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5

- 9 TOTAL HOURS WORKED
- 10 AHSEA (SEE INSTRUCTIONS)
- 11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)
- 12 NUMBER OF TRAVEL HOURS  
(SEE INSTRUCTIONS)
- 12.01 NUMBER OF TRAVEL HOURS OFFSITE  
(SEE INSTRUCTIONS)
- 13 NUMBER OF MILES DRIVEN  
(SEE INSTRUCTIONS)
- 13.01 NUMBER OF MILES DRIVEN OFFSITE  
(SEE INSTRUCTIONS)

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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

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

RESPIRATORY THERAPY

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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

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

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

I PROVIDER NO:  
I 15-1309  
I

IN LIEU OF FORM  
I PERIOD:  
I FROM 7/ 1/2006  
I TO 6/30/2007

CMS-2552-96(12/1999)  
I PREPARED 11/26/2007  
I WORKSHEET A-8-4  
I PARTS I - VII

RESPIRATORY THERAPY

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

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

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

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

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

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

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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

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

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

HEALTH FINANCIAL SYSTEMS      MCRS/PC-WIN      FOR ST. VINCENT CLAY HOSPITAL      IN LIEU OF FORM CMS-2552-96(12/1999)  
REASONABLE COST DETERMINATION FOR THERAPY      I PROVIDER NO:      I PERIOD:      I PREPARED 11/26/2007  
SERVICES FURNISHED BY OUTSIDE SUPPLIERS      I 15-1309      I FROM 7/ 1/2006      I WORKSHEET A-8-4  
ON OR AFTER APRIL 10, 1998      I      I TO 6/30/2007      I PARTS I - VII  
OCCUPATIONAL THERAPY

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

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	26
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	390
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	35
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		39.00		
10	AHSEA (SEE INSTRUCTIONS)		59.97		
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	29.99	29.99		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	2,339
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	2,339
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	2,339

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	59.97
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	23,388
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	23,388

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

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

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

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

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

SPEECH PATHOLOGY

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	23,388
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	1,050
59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)	
61 EQUIPMENT COST (SEE INSTRUCTIONS)	
62 SUPPLIES (SEE INSTRUCTIONS)	
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	24,438
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	3,789
65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66 COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	3,789
66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS) (FROM YOUR RECORDS)	
67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS) (THIS LINE MUST AGREE WITH LINE 64)	3,789
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS) (TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

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

I PROVIDER NO:  
I 15-1309  
I

IN LIEU OF FORM CMS-2552-96(12/1999)  
I PERIOD:  
I FROM 7/ 1/2006  
I TO 6/30/2007

I PREPARED 11/26/2007  
I WORKSHEET A-8-4  
I PARTS I - VII

SPEECH PATHOLOGY

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

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I NOT A CMS WORKSHEET  
 I I TO 6/30/2007 I

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	SQUARE	FEET	NOT ENTERED
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	SQUARE	FEET	ENTERED
4.01	NEW CAP REL COSTS-MOB BLDG	41	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	42	SQAURE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	44	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	60	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	EMPLOYEE	HOURS	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		REVENUS	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	NET EXPENSES FOR COST ALLOCATION	OLD CAP REL OSTS-BLDG &	OLD CAP REL OSTS-MVBLE E	NEW CAP REL OSTS-BLDG &	NEW CAP REL OSTS-MVBLE E	NEW CAP REL OSTS-MOB BLD	EMPLOYEE BENE FITS
		0	1	2	3	4	4.01	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 &	410,951			410,951			
004	NEW CAP REL COSTS-MVBLE E	775,792						
004	01 NEW CAP REL COSTS-MOB BLD	325,474				775,792		
005	EMPLOYEE BENEFITS	1,769,247					325,474	
006	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	3,113,706			126,376	244,587	16,225	1,769,247
007								375,986
008	OPERATION OF PLANT	776,372			84,335	163,223		88,149
009	LAUNDRY & LINEN SERVICE	81,186			8,815	17,060		
010	HOUSEKEEPING	254,084			4,888	9,461		64,342
011	DIETARY	174,623			10,858	21,014		39,552
012	CAFETERIA	133,623			6,159	11,920		38,707
013	MAINTENANCE OF PERSONNEL							
014	NURSING ADMINISTRATION	385,505			1,345	2,604		109,798
015	CENTRAL SERVICES & SUPPLY	128,451			7,459	14,437		
016	PHARMACY	365,926			4,823	9,335		
017	MEDICAL RECORDS & LIBRARY	183,151			42,763	82,764		52,534
018	SOCIAL SERVICE							
020	NONPHYSICIAN ANESTHETISTS							
021	NURSING SCHOOL							
022	I&R SERVICES-SALARY & FRI							
023	I&R SERVICES-OTHER PRGM C							
024	PARAMED ED PRGM							
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS	1,134,292			27,759	53,726		325,227
027	INTENSIVE CARE UNIT							
028	CORONARY CARE UNIT							
029	BURN INTENSIVE CARE UNIT							
031	SURGICAL INTENSIVE CARE U							
033	SUBPROVIDER							
034	NURSERY							
035	SKILLED NURSING FACILITY							
036	01 NURSING FACILITY							
037	ICF/MR							
038	OTHER LONG TERM CARE							
039	ANCILLARY SRVC COST CNTRS							
040	OPERATING ROOM	614,527			11,396	22,056		130,394
041	RECOVERY ROOM							
042	DELIVERY ROOM & LABOR ROO							
043	ANESTHESIOLOGY							
044	RADIOLOGY-DIAGNOSTIC	1,341,184			7,903	15,295		173,124
045	RADIOLOGY-THERAPEUTIC							
046	RADIOISOTOPE							
047	LABORATORY	1,186,074			6,463	12,508	12,967	104,755
048	PBP CLINICAL LAB SERVICES							
049	WHOLE BLOOD & PACKED RED							
050	BLOOD STORING, PROCESSING							
051	INTRAVENOUS THERAPY							
052	RESPIRATORY THERAPY	152,301			7,793	15,083		34,690
053	PHYSICAL THERAPY	393,573			8,277	16,018	38,280	
054	OCCUPATIONAL THERAPY							
055	SPEECH PATHOLOGY	3,789						
056	ELECTROCARDIOLOGY	138,449						34,605
057	ELECTROENCEPHALOGRAPHY							
058	MEDICAL SUPPLIES CHARGED	722,867						
059	DRUGS CHARGED TO PATIENTS	596,574						
060	RENAL DIALYSIS							
061	ASC (NON-DISTINCT PART)							
062	OUTPAT SERVICE COST CNTRS							
063	CLINIC							
064	EMERGENCY	1,066,817			22,866	44,256		188,520
065	OBSERVATION BEDS (NON-DIS							
066	OTHER REIMBURS COST CNTRS							
067	HOME PROGRAM DIALYSIS							
068	AMBULANCE SERVICES							
069	DURABLE MEDICAL EQUIP-REN				10,110			
070	DURABLE MEDICAL EQUIP-SOL							
071	CORF							
072	I&R SERVICES-NOT APPRVD P							
073	HOME HEALTH AGENCY							
074	LUNG ACQUISITION							
075	SPEC PURPOSE COST CENTERS							
076	KIDNEY ACQUISITION							
077	LIVER ACQUISITION							
078	HEART ACQUISITION							
079	01 PANCREAS ACQUISITION							
080	OTHER ORGAN ACQUISITION							
081	AMBULATORY SURGICAL CENTE							
082	HOSPICE							
083	SUBTOTALS	16,228,538			400,388	755,347	67,472	1,760,383
084	NONREIMBURS COST CENTERS							
085	GIFT, FLOWER, COFFEE SHOP				1,056	2,045		
086	RESEARCH							
087	PHYSICIANS' PRIVATE OFFIC							
088	01 PHYSICIANS' PRIVATE OFFIC	15,911					258,002	18
089	02 CLAY COUNTY CLINIC	303,044						
090	03 MISSION SERVICES	12,589						2,221
091	04 PUBLIC RELATIONS	108,266			249	482		6,625
092	NONPAID WORKERS							
093	OTHER NONREIMBURSABLE COS				9,258	17,918		
094	CROSS FOOT ADJUSTMENT							
095	NEGATIVE COST CENTER							
096	TOTAL	16,668,348			410,951	775,792	325,474	1,769,247

COST ALLOCATION - GENERAL SERVICE COSTS

PROVIDER NO: 15-1309  
 I PERIOD: 7/ 1/2006 TO 6/30/2007  
 I PREPARED 11/26/2007  
 I WORKSHEET B  
 I PART I

COST CENTER DESCRIPTION	SUBTOTAL	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	5a.00	6	7	8	9	10	11
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL	3,876,880	3,876,880					
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	1,112,079	337,052		1,449,131			
010 LAUNDRY & LINEN SERVICE	107,061	32,448		58,168	197,677		
011 HOUSEKEEPING	332,775	100,858		32,257	6,916	472,806	
012 DIETARY	246,047	74,573		71,649	3,244	15,050	410,563
013 CAFETERIA	190,409	57,710		40,642		3,135	
014 MAINTENANCE OF PERSONNEL							
015 NURSING ADMINISTRATION	499,252	151,315		8,878		21,947	
016 CENTRAL SERVICES & SUPPLY	150,347	45,568		49,224			
017 PHARMACY	380,084	115,197		31,830			
018 MEDICAL RECORDS & LIBRARY	361,212	109,477		282,192		5,644	
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	1,541,004	467,055		183,184	70,884	140,461	410,563
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	778,373	235,912		75,201	29,386	43,267	
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC	1,537,506	465,992		52,150	24,945	25,083	
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
045 LABORATORY	1,322,767	400,908		74,970		34,489	
046 PBP CLINICAL LAB SERVICES							
047 WHOLE BLOOD & PACKED RED							
048 BLOOD STORING, PROCESSING							
049 INTRAVENOUS THERAPY							
050 RESPIRATORY THERAPY	209,867	63,607		51,427			
051 PHYSICAL THERAPY	456,148	138,251		150,039	6,607	37,624	
052 OCCUPATIONAL THERAPY							
053 SPEECH PATHOLOGY	3,789	1,148					
054 ELECTROCARDIOLOGY	173,054	52,450				12,541	
055 ELECTROENCEPHALOGRAPHY							
056 MEDICAL SUPPLIES CHARGED	722,867	219,089					
057 DRUGS CHARGED TO PATIENTS	596,574	180,811					9,406
058 RENAL DIALYSIS							
059 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY	1,322,459	400,815		150,894	55,695	124,159	
063 OBSERVATION BEDS (NON-DIS							
064 OTHER REIMBURS COST CNTRS							
065 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES	10,110	3,064		66,717			
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	15,930,664	3,653,300		1,379,422	197,677	472,806	410,563
082 NONREIMBURS COST CENTERS							
083 GIFT, FLOWER, COFFEE SHOP	3,101	940		6,971			
084 RESEARCH							
085 PHYSICIANS' PRIVATE OFFIC							
086 01 PHYSICIANS' PRIVATE OFFIC	273,931	83,024					
087 02 CLAY COUNTY CLINIC	303,044	91,847					
088 03 MISSION SERVICES	14,810	4,489					
089 04 PUBLIC RELATIONS	115,622	35,043		1,644			
090 NONPAID WORKERS							
091 OTHER NONREIMBURSABLE COS	27,176	8,237		61,094			
092 CROSS FOOT ADJUSTMENT							
093 NEGATIVE COST CENTER							
094 TOTAL	16,668,348	3,876,880		1,449,131	197,677	472,806	410,563

COST CENTER DESCRIPTION	CAFETERIA 12	MAINTENANCE O F PERSONNEL 13	NURSING ADMINISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SOCIAL SERVIC E 18
GENERAL SERVICE COST CNTR							
001 OLD CAP REL COSTS-BLDG &							
002 OLD CAP REL COSTS-MVBLE E							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA	291,896						
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION	21,534		702,926				
015 CENTRAL SERVICES & SUPPLY				245,139			
016 PHARMACY					527,111		
017 MEDICAL RECORDS & LIBRARY	19,725					778,250	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	78,667		361,703			41,382	
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	30,744		141,355			82,266	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY	2,847						
041 RADIOLOGY-DIAGNOSTIC	38,111					210,876	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY	29,103					150,522	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY	6,162					23,574	
050 PHYSICAL THERAPY						39,056	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							260
053 ELECTROCARDIOLOGY	8,707					27,675	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED				245,139		37,883	
056 DRUGS CHARGED TO PATIENTS					527,111	58,194	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY	43,470		199,868			106,562	
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS	279,070		702,926	245,139	527,111	778,250	
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC							
098 02 CLAY COUNTY CLINIC	10,985						
098 03 MISSION SERVICES	167						
098 04 PUBLIC RELATIONS	1,674						
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	291,896		702,926	245,139	527,111	778,250	

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	I&R COST POST STEP-DOWN ADJ
	20	21	22	23	24	25	26
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
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							
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						3,294,903	
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						1,416,504	
042 RECOVERY ROOM							
043 DELIVERY ROOM & LABOR ROO							
044 ANESTHESIOLOGY							2,847
045 RADIOLOGY-DIAGNOSTIC						2,354,663	
046 RADIOLOGY-THERAPEUTIC							
047 RADIOISOTOPE							
048 LABORATORY						2,012,759	
049 PBP CLINICAL LAB SERVICES							
050 WHOLE BLOOD & PACKED RED							
051 BLOOD STORING, PROCESSING							
052 INTRAVENOUS THERAPY							
053 RESPIRATORY THERAPY						354,637	
054 PHYSICAL THERAPY						827,725	
055 OCCUPATIONAL THERAPY							5,197
056 SPEECH PATHOLOGY							274,427
057 ELECTROCARDIOLOGY							
058 ELECTROENCEPHALOGRAPHY							
060 MEDICAL SUPPLIES CHARGED						1,224,978	
061 DRUGS CHARGED TO PATIENTS						1,372,096	
062 RENAL DIALYSIS							
063 ASC (NON-DISTINCT PART)							
064 OUTPUT SERVICE COST CNTRS							
065 CLINIC							
066 EMERGENCY						2,403,922	
067 OBSERVATION BEDS (NON-DIS							
068 OTHER REIMBURS COST CNTRS							
069 HOME PROGRAM DIALYSIS							
070 AMBULANCE SERVICES						79,891	
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						15,624,549	
086 NONREIMBURS COST CENTERS							
087 GIFT, FLOWER, COFFEE SHOP						11,012	
088 RESEARCH							
089 PHYSICIANS' PRIVATE OFFIC							
090 01 PHYSICIANS' PRIVATE OFFIC						356,955	
091 02 CLAY COUNTY CLINIC						405,876	
092 03 MISSION SERVICES						19,466	
093 04 PUBLIC RELATIONS						153,983	
094 NONPAID WORKERS							
095 OTHER NONREIMBURSABLE COS						96,507	
096 CROSS FOOT ADJUSTMENT							
097 NEGATIVE COST CENTER							
098 TOTAL						16,668,348	

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	TOTAL
	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 &	
004 01 NEW CAP REL COSTS-MVBLE E	
005 EMPLOYEE BENEFITS	
006 ADMINISTRATIVE & GENERAL	
007 MAINTENANCE & REPAIRS	
008 OPERATION OF PLANT	
009 LAUNDRY & LINEN SERVICE	
010 HOUSEKEEPING	
011 DIETARY	
012 CAFETERIA	
013 MAINTENANCE OF PERSONNEL	
014 NURSING ADMINISTRATION	
015 CENTRAL SERVICES & SUPPLY	
016 PHARMACY	
017 MEDICAL RECORDS & LIBRARY	
018 SOCIAL SERVICE	
020 NONPHYSICIAN ANESTHETISTS	
021 NURSING SCHOOL	
022 I&R SERVICES-SALARY & FRI	
023 I&R SERVICES-OTHER PRGM C	
024 PARAMED ED PRGM	
025 INPAT ROUTINE SRVC CNTRS	3,294,903
026 ADULTS & PEDIATRICS	
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	
035 01 NURSING FACILITY	
036 ICF/MR	
037 OTHER LONG TERM CARE	
038 ANCILLARY SRVC COST CNTRS	1,416,504
039 OPERATING ROOM	
040 RECOVERY ROOM	
040 DELIVERY ROOM & LABOR ROO	2,847
041 ANESTHESIOLOGY	
041 RADIOLOGY-DIAGNOSTIC	2,354,663
042 RADIOLOGY-THERAPEUTIC	
043 RADIOISOTOPE	
044 LABORATORY	2,012,759
045 PBP CLINICAL LAB SERVICES	
046 WHOLE BLOOD & PACKED RED	
047 BLOOD STORING, PROCESSING	
048 INTRAVENOUS THERAPY	
049 RESPIRATORY THERAPY	354,637
050 PHYSICAL THERAPY	827,725
051 OCCUPATIONAL THERAPY	
052 SPEECH PATHOLOGY	5,197
053 ELECTROCARDIOLOGY	274,427
054 ELECTROENCEPHALOGRAPHY	
055 MEDICAL SUPPLIES CHARGED	1,224,978
056 DRUGS CHARGED TO PATIENTS	1,372,096
057 RENAL DIALYSIS	
058 ASC (NON-DISTINCT PART)	
060 OUTPAT SERVICE COST CNTRS	
061 CLINIC	
061 EMERGENCY	2,403,922
062 OBSERVATION BEDS (NON-DIS	
064 OTHER REIMBURS COST CNTRS	
064 HOME PROGRAM DIALYSIS	
065 AMBULANCE SERVICES	79,891
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	
084 KIDNEY ACQUISITION	
084 LIVER ACQUISITION	
085 HEART ACQUISITION	
085 01 PANCREAS ACQUISITION	
086 OTHER ORGAN ACQUISITION	
092 AMBULATORY SURGICAL CENTE	
093 HOSPICE	
095 SUBTOTALS	15,624,549
096 NONREIMBURS COST CENTERS	
097 GIFT, FLOWER, COFFEE SHOP	11,012
097 RESEARCH	
098 PHYSICIANS' PRIVATE OFFIC	
098 01 PHYSICIANS' PRIVATE OFFIC	356,955
098 02 CLAY COUNTY CLINIC	405,876
098 03 MISSION SERVICES	19,466
098 04 PUBLIC RELATIONS	153,983
099 NONPAID WORKERS	
100 OTHER NONREIMBURSABLE COS	96,507
101 CROSS FOOT ADJUSTMENT	
102 NEGATIVE COST CENTER	
103 TOTAL	16,668,348

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 15-1309  
 I PERIOD: FROM 7/1/2006 TO 6/30/2007  
 I PREPARED 11/26/2007  
 I WORKSHEET B  
 I PART III

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	NEW CAP REL C OSTS-MOB BLD	SUBTOTAL
	0	1	2	3	4	4.01	4a
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL				126,376	244,587	16,225	387,188
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT				84,335	163,223		247,558
009 LAUNDRY & LINEN SERVICE				8,815	17,060		25,875
010 HOUSEKEEPING				4,888	9,461		14,349
011 DIETARY				10,858	21,014		31,872
012 CAFETERIA				6,159	11,920		18,079
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION				1,345	2,604		3,949
015 CENTRAL SERVICES & SUPPLY				7,459	14,437		21,896
016 PHARMACY				4,823	9,335		14,158
017 MEDICAL RECORDS & LIBRARY				42,763	82,764		125,527
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS				27,759	53,726		81,485
027 INTENSIVE CARE UNIT							
028 CORONARY CARE UNIT							
029 BURN INTENSIVE CARE UNIT							
031 SURGICAL INTENSIVE CARE U							
033 SUBPROVIDER							
034 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
038 OPERATING ROOM				11,396	22,056		33,452
039 RECOVERY ROOM							
040 DELIVERY ROOM & LABOR ROO							
041 ANESTHESIOLOGY							
042 RADIOLOGY-DIAGNOSTIC				7,903	15,295		23,198
043 RADIOLOGY-THERAPEUTIC							
044 RADIOISOTOPE							
044 LABORATORY				6,463	12,508	12,967	31,938
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY				7,793	15,083		22,876
050 PHYSICAL THERAPY				8,277	16,018	38,280	62,575
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY							
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
062 EMERGENCY				22,866	44,256		67,122
064 OBSERVATION BEDS (NON-DIS							
065 OTHER REIMBURS COST CNTRS							
066 HOME PROGRAM DIALYSIS							
066 AMBULANCE SERVICES				10,110			10,110
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							
085 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS				400,388	755,347	67,472	1,223,207
096 NONREIMBURS COST CENTERS							
097 GIFT, FLOWER, COFFEE SHOP				1,056	2,045		3,101
098 RESEARCH							
098 01 PHYSICIANS' PRIVATE OFFIC						258,002	258,002
098 02 CLAY COUNTY CLINIC							
098 03 MISSION SERVICES							
098 04 PUBLIC RELATIONS				249	482		731
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS				9,258	17,918		27,176
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL				410,951	775,792	325,474	1,512,217

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
	5	6	7	8	9	10	11
001 GENERAL SERVICE COST CNTR							
002 OLD CAP REL COSTS-BLDG &							
003 OLD CAP REL COSTS-MVBLE E							
004 NEW CAP REL COSTS-BLDG &							
004 01 NEW CAP REL COSTS-MVBLE E							
005 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		387,188					
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT		33,662		281,220			
009 LAUNDRY & LINEN SERVICE		3,241		11,288	40,404		
010 HOUSEKEEPING		10,073		6,260	1,414	32,096	
011 DIETARY		7,448		13,904	663	1,022	54,909
012 CAFETERIA		5,763		7,887		213	
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION		15,112		1,723		1,490	
015 CENTRAL SERVICES & SUPPLY		4,551		9,552			
016 PHARMACY		11,505		6,177			
017 MEDICAL RECORDS & LIBRARY		10,934		54,762		383	
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		46,644		35,549	14,488	9,535	54,909
027 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		23,561		14,594	6,006	2,937	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							
041 RADIOLOGY-DIAGNOSTIC		46,539		10,120	5,099	1,703	
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY		40,039		14,549		2,341	
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY		6,352		9,980			
050 PHYSICAL THERAPY		13,807		29,117	1,350	2,554	
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY		115					
053 ELECTROCARDIOLOGY		5,238				851	
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED		21,880					
056 DRUGS CHARGED TO PATIENTS		18,058				639	
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC							
061 EMERGENCY		40,030		29,283	11,384	8,428	
062 OBSERVATION BEDS (NON-DIS							
062 OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES		306		12,947			
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		364,858		267,692	40,404	32,096	54,909
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		94		1,353			
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC		8,292					
098 02 CLAY COUNTY CLINIC		9,173					
098 03 MISSION SERVICES		448					
098 04 PUBLIC RELATIONS		3,500		319			
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS		823		11,856			
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		387,188		281,220	40,404	32,096	54,909

	COST CENTER DESCRIPTION	CAFETERIA 12	MAINTENANCE O F PERSONNEL 13	NURSING ADMIN ISTRATION 14	CENTRAL SERVI CES & SUPPLY 15	PHARMACY 16	MEDICAL RECOR DS & LIBRARY 17	SOCIAL SERVIC E 18
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	01 NEW CAP REL COSTS-MOB BLD							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT							
010	LAUNDRY & LINEN SERVICE							
011	HOUSEKEEPING							
012	DIETARY							
012	CAFETERIA	31,942						
013	MAINTENANCE OF PERSONNEL							
014	NURSING ADMINISTRATION	2,356		24,630				
015	CENTRAL SERVICES & SUPPLY				35,999			
016	PHARMACY					31,840		
017	MEDICAL RECORDS & LIBRARY	2,159					193,765	
018	SOCIAL SERVICE							
020	NONPHYSICIAN ANESTHETISTS							
021	NURSING SCHOOL							
022	I&R SERVICES-SALARY & FRI							
023	I&R SERVICES-OTHER PRGM C							
024	PARAMED ED PRGM							
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS	8,609		12,674			10,303	
027	INTENSIVE CARE UNIT							
028	CORONARY CARE UNIT							
029	BURN INTENSIVE CARE UNIT							
031	SURGICAL INTENSIVE CARE U							
033	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	3,364		4,953			20,483	
038	RECOVERY ROOM							
039	DELIVERY ROOM & LABOR ROO							
040	ANESTHESIOLOGY	312						
041	RADIOLOGY-DIAGNOSTIC	4,170					52,501	
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY	3,185					37,477	
045	PBP CLINICAL LAB SERVICES							
046	WHOLE BLOOD & PACKED RED							
047	BLOOD STORING, PROCESSING							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	674					5,869	
050	PHYSICAL THERAPY						9,724	
051	OCCUPATIONAL THERAPY							
052	SPEECH PATHOLOGY						65	
053	ELECTROCARDIOLOGY	953					6,890	
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED				35,999		9,432	
056	DRUGS CHARGED TO PATIENTS					31,840	14,489	
057	RENAL DIALYSIS							
058	ASC (NON-DISTINCT PART)							
060	OUTPAT SERVICE COST CNTRS							
061	CLINIC							
062	EMERGENCY	4,757		7,003			26,532	
062	OBSERVATION BEDS (NON-DIS							
064	OTHER REIMBURS COST CNTRS							
065	HOME PROGRAM DIALYSIS							
066	AMBULANCE SERVICES							
067	DURABLE MEDICAL EQUIP-REN							
067	DURABLE MEDICAL EQUIP-SOL							
069	CORF							
070	I&R SERVICES-NOT APPRVD P							
071	HOME HEALTH AGENCY							
082	LUNG ACQUISITION							
083	SPEC PURPOSE COST CENTERS							
083	KIDNEY ACQUISITION							
084	LIVER ACQUISITION							
085	HEART ACQUISITION							
085	01 PANCREAS ACQUISITION							
086	OTHER ORGAN ACQUISITION							
092	AMBULATORY SURGICAL CENTE							
093	HOSPICE							
095	SUBTOTALS	30,539		24,630	35,999	31,840	193,765	
096	NONREIMBURS COST CENTERS							
097	GIFT, FLOWER, COFFEE SHOP							
098	RESEARCH							
098	PHYSICIANS' PRIVATE OFFIC							
098	01 PHYSICIANS' PRIVATE OFFIC							
098	02 CLAY COUNTY CLINIC	1,202						
098	03 MISSION SERVICES	18						
098	04 PUBLIC RELATIONS	183						
099	NONPAID WORKERS							
100	OTHER NONREIMBURSABLE COS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	31,942		24,630	35,999	31,840	193,765	

ALLOCATION OF NEW CAPITAL RELATED COSTS

PROVIDER NO: 15-1309 I PERIOD: FROM 7/1/2006 TO 6/30/2007 I PREPARED 11/26/2007 I WORKSHEET B PART III

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES-SALARY & FRI	I&R SERVICES-OTHER PRGM C	PARAMED ED PR GM	SUBTOTAL	POST STEPDOWN ADJUSTMENT
	20	21	22	23	24	25	26
GENERAL SERVICE COST CNTR							
001 OLD CAP REL COSTS-BLDG &							
002 OLD CAP REL COSTS-MVBLE E							
003 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
004 01 NEW CAP REL COSTS-MOB BLD							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
007 MAINTENANCE & REPAIRS							
008 OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING							
011 DIETARY							
012 CAFETERIA							
013 MAINTENANCE OF PERSONNEL							
014 NURSING ADMINISTRATION							
015 CENTRAL SERVICES & SUPPLY							
016 PHARMACY							
017 MEDICAL RECORDS & LIBRARY							
018 SOCIAL SERVICE							
020 NONPHYSICIAN ANESTHETISTS							
021 NURSING SCHOOL							
022 I&R SERVICES-SALARY & FRI							
023 I&R SERVICES-OTHER PRGM C							
024 PARAMED ED PRGM							
INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS						274,196	
026 INTENSIVE CARE UNIT							
027 CORONARY CARE UNIT							
028 BURN INTENSIVE CARE UNIT							
029 SURGICAL INTENSIVE CARE U							
031 SUBPROVIDER							
033 NURSERY							
034 SKILLED NURSING FACILITY							
035 NURSING FACILITY							
035 01 ICF/MR							
036 OTHER LONG TERM CARE							
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM						109,350	
038 RECOVERY ROOM							
039 DELIVERY ROOM & LABOR ROO							
040 ANESTHESIOLOGY							312
041 RADIOLOGY-DIAGNOSTIC							143,330
042 RADIOLOGY-THERAPEUTIC							
043 RADIOISOTOPE							
044 LABORATORY							129,529
045 PBP CLINICAL LAB SERVICES							
046 WHOLE BLOOD & PACKED RED							
047 BLOOD STORING, PROCESSING							
048 INTRAVENOUS THERAPY							
049 RESPIRATORY THERAPY							45,751
050 PHYSICAL THERAPY							119,127
051 OCCUPATIONAL THERAPY							
052 SPEECH PATHOLOGY							180
053 ELECTROCARDIOLOGY							13,932
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							67,311
056 DRUGS CHARGED TO PATIENTS							65,026
057 RENAL DIALYSIS							
058 ASC (NON-DISTINCT PART)							
OUTPAT SERVICE COST CNTRS							
060 CLINIC							
061 EMERGENCY							194,539
062 OBSERVATION BEDS (NON-DIS							
OTHER REIMBURS COST CNTRS							
064 HOME PROGRAM DIALYSIS							
065 AMBULANCE SERVICES							23,363
066 DURABLE MEDICAL EQUIP-REN							
067 DURABLE MEDICAL EQUIP-SOL							
069 CORF							
070 I&R SERVICES-NOT APPRVD P							
071 HOME HEALTH AGENCY							
082 LUNG ACQUISITION							
SPEC PURPOSE COST CENTERS							
083 KIDNEY ACQUISITION							
084 LIVER ACQUISITION							
085 HEART ACQUISITION							
085 01 PANCREAS ACQUISITION							
086 OTHER ORGAN ACQUISITION							
092 AMBULATORY SURGICAL CENTE							
093 HOSPICE							
095 SUBTOTALS						1,185,946	
NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							4,548
097 RESEARCH							
098 PHYSICIANS' PRIVATE OFFIC							
098 01 PHYSICIANS' PRIVATE OFFIC							266,294
098 02 CLAY COUNTY CLINIC							10,375
098 03 MISSION SERVICES							466
098 04 PUBLIC RELATIONS							4,733
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS							39,855
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL						1,512,217	

TOTAL

		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 &	
004	NEW CAP REL COSTS-MVBLE E	
004	01 NEW CAP REL COSTS-MOB BLD	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
013	MAINTENANCE OF PERSONNEL	
014	NURSING ADMINISTRATION	
015	CENTRAL SERVICES & SUPPLY	
016	PHARMACY	
017	MEDICAL RECORDS & LIBRARY	
018	SOCIAL SERVICE	
020	NONPHYSICIAN ANESTHETISTS	
021	NURSING SCHOOL	
022	I&R SERVICES-SALARY & FRI	
023	I&R SERVICES-OTHER PRGM C	
024	PARAMED ED PRGM	
025	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	274,196
026	INTENSIVE CARE UNIT	
027	CORONARY CARE UNIT	
028	BURN INTENSIVE CARE UNIT	
029	SURGICAL INTENSIVE CARE U	
031	SUBPROVIDER	
033	NURSERY	
034	SKILLED NURSING FACILITY	
035	NURSING FACILITY	
035	01 ICF/MR	
036	OTHER LONG TERM CARE	
037	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	109,350
038	RECOVERY ROOM	
039	DELIVERY ROOM & LABOR ROO	
040	ANESTHESIOLOGY	312
041	RADIOLOGY-DIAGNOSTIC	143,330
042	RADIOLOGY-THERAPEUTIC	
043	RADIOISOTOPE	
044	LABORATORY	129,529
045	PBP CLINICAL LAB SERVICES	
046	WHOLE BLOOD & PACKED RED	
047	BLOOD STORING, PROCESSING	
048	INTRAVENOUS THERAPY	
049	RESPIRATORY THERAPY	45,751
050	PHYSICAL THERAPY	119,127
051	OCCUPATIONAL THERAPY	
052	SPEECH PATHOLOGY	180
053	ELECTROCARDIOLOGY	13,932
054	ELECTROENCEPHALOGRAPHY	
055	MEDICAL SUPPLIES CHARGED	67,311
056	DRUGS CHARGED TO PATIENTS	65,026
057	RENAL DIALYSIS	
058	ASC (NON-DISTINCT PART)	
060	OUTPUT SERVICE COST CNTRS	
061	CLINIC	
061	EMERGENCY	194,539
062	OBSERVATION BEDS (NON-DIS	
064	OTHER REIMBURS COST CNTRS	
064	HOME PROGRAM DIALYSIS	
065	AMBULANCE SERVICES	23,363
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	1,185,946
096	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	4,548
097	RESEARCH	
098	PHYSICIANS' PRIVATE OFFIC	
098	01 PHYSICIANS' PRIVATE OFFIC	266,294
098	02 CLAY COUNTY CLINIC	10,375
098	03 MISSION SERVICES	466
098	04 PUBLIC RELATIONS	4,733
099	NONPAID WORKERS	
100	OTHER NONREIMBURSABLE COS	39,855
101	CROSS FOOT ADJUSTMENTS	
102	NEGATIVE COST CENTER	
103	TOTAL	1,512,217

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET B-1  
 I I TO 6/30/2007 I

COST CENTER DESCRIPTION	OLD CAP REL C	OLD CAP REL C	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE
	OSTS-BLDG & ( SQUARE FEET )	OSTS-MVBLE E ( SQUARE FEET )	OSTS-BLDG & ( SQUARE FEET )	OSTS-MVBLE E ( SQUARE FEET )	OSTS-MOB BLD ( SQUARE FEET )	FITS ( GROSS SALARIES )
	1	2	3	4	4.01	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 &			82,473			
004 01 NEW CAP REL COSTS-MVBLE E				80,444		
005 EMPLOYEE BENEFITS					24,674	
006 ADMINISTRATIVE & GENERAL			25,362	25,362	1,230	5,551,219
007 MAINTENANCE & REPAIRS						1,179,689
008 OPERATION OF PLANT			16,925	16,925		276,578
009 LAUNDRY & LINEN SERVICE			1,769	1,769		
010 HOUSEKEEPING			981	981		201,882
011 DIETARY			2,179	2,179		124,100
012 CAFETERIA			1,236	1,236		121,448
013 MAINTENANCE OF PERSONNEL						
014 NURSING ADMINISTRATION			270	270		344,503
015 CENTRAL SERVICES & SUPPLY			1,497	1,497		
016 PHARMACY			968	968		
017 MEDICAL RECORDS & LIBRARY			8,582	8,582		164,833
018 SOCIAL SERVICE						
020 NONPHYSICIAN ANESTHETISTS						
021 NURSING SCHOOL						
022 I&R SERVICES-SALARY & FRI						
023 I&R SERVICES-OTHER PRGM C						
024 PARAMED ED PRGM						
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS			5,571	5,571		1,020,440
027 INTENSIVE CARE UNIT						
028 CORONARY CARE UNIT						
028 BURN INTENSIVE CARE UNIT						
029 SURGICAL INTENSIVE CARE U						
031 SUBPROVIDER						
033 NURSERY						
034 SKILLED NURSING FACILITY						
035 NURSING FACILITY						
035 01 ICF/MR						
036 OTHER LONG TERM CARE						
037 ANCILLARY SRVC COST CNTRS						
038 OPERATING ROOM			2,287	2,287		409,126
039 RECOVERY ROOM						
040 DELIVERY ROOM & LABOR ROO						
041 ANESTHESIOLOGY						
042 RADIOLOGY-DIAGNOSTIC			1,586	1,586		543,197
043 RADIOLOGY-THERAPEUTIC						
044 RADIOISOTOPE						
044 LABORATORY			1,297	1,297	983	328,682
045 PBP CLINICAL LAB SERVICES						
046 WHOLE BLOOD & PACKED RED						
047 BLOOD STORING, PROCESSING						
048 INTRAVENOUS THERAPY						
049 RESPIRATORY THERAPY			1,564	1,564		108,844
050 PHYSICAL THERAPY			1,661	1,661	2,902	
051 OCCUPATIONAL THERAPY						
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY						108,578
054 ELECTROENCEPHALOGRAPHY						
055 MEDICAL SUPPLIES CHARGED						
056 DRUGS CHARGED TO PATIENTS						
057 RENAL DIALYSIS						
058 ASC (NON-DISTINCT PART)						
060 OUTPAT SERVICE COST CNTRS						
061 CLINIC						
062 EMERGENCY			4,589	4,589		591,505
064 OBSERVATION BEDS (NON-DIS						
065 OTHER REIMBURS COST CNTRS						
066 HOME PROGRAM DIALYSIS						
067 AMBULANCE SERVICES						
069 DURABLE MEDICAL EQUIP-REN			2,029			
070 DURABLE MEDICAL EQUIP-SOL						
071 CORF						
070 I&R SERVICES-NOT APPRVD P						
071 HOME HEALTH AGENCY						
082 LUNG ACQUISITION						
083 SPEC PURPOSE COST CENTERS						
084 KIDNEY ACQUISITION						
084 LIVER ACQUISITION						
085 HEART ACQUISITION						
085 01 PANCREAS ACQUISITION						
086 OTHER ORGAN ACQUISITION						
092 AMBULATORY SURGICAL CENTE						
093 HOSPICE						
095 SUBTOTALS			80,353	78,324	5,115	5,523,405
096 NONREIMBURS COST CENTERS						
097 GIFT, FLOWER, COFFEE SHOP			212	212		
098 RESEARCH						
098 PHYSICIANS' PRIVATE OFFIC						
098 01 PHYSICIANS' PRIVATE OFFIC					19,559	57
098 02 CLAY COUNTY CLINIC						
098 03 MISSION SERVICES						6,970
098 04 PUBLIC RELATIONS			50	50		20,787
099 NONPAID WORKERS						

COST CENTER  
 DESCRIPTION

OLD CAP REL C OLD CAP REL C NEW CAP REL C NEW CAP REL C NEW CAP REL C EMPLOYEE BENE  
 OST-S-BLDG & OST-S-MVBLE E OST-S-BLDG & OST-S-MVBLE E OST-S-MOB BLD FITS

( SQUARE ) ( GROSS  
 FEET ) FEET ) FEET ) FEET ) FEET ) SALARIES )

	1	2	3	4	4.01	5
NONREIMBURS COST CENTERS						
100 OTHER NONREIMBURSABLE COS						
101 CROSS FOOT ADJUSTMENT			1,858	1,858		
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED (WRKSHT B, PART I)			410,951	775,792	325,474	1,769,247
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)			4.982855	9.643876	13.190970	
105 COST TO BE ALLOCATED (WRKSHT B, PART II)						.318713
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

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET B-1  
 I I TO 6/30/2007 I

	COST CENTER DESCRIPTION	RECONCILIATION	ADMINISTRATIVE & GENERAL		MAINTENANCE & REPAIRS		OPERATION OF PLANT		LAUNDRY & LINEN SERVICE		HOUSEKEEPING		DIETARY	
			( ACCUM. COST )	( SQUARE FEET )	( SQUARE FEET )	( POUNDS OF LAUNDRY )	( HOURS OF SERVICE )	( MEALS SERVED )						
		6a.00	6	7	8	9	10	11						
001	GENERAL SERVICE COST CNTR													
002	OLD CAP REL COSTS-BLDG &													
003	OLD CAP REL COSTS-MVBLE E													
004	NEW CAP REL COSTS-BLDG &													
004	NEW CAP REL COSTS-MVBLE E													
005	01 NEW CAP REL COSTS-MOB BLD													
006	EMPLOYEE BENEFITS													
007	ADMINISTRATIVE & GENERAL	-3,876,880	12,791,468											
008	MAINTENANCE & REPAIRS													
009	OPERATION OF PLANT		1,112,079		44,071									
010	LAUNDRY & LINEN SERVICE		107,061		1,769		108,962							
011	HOUSEKEEPING		332,775		981		3,812		754					
012	DIETARY		246,047		2,179		1,788		24					100
013	CAFETERIA		190,409		1,236				5					
014	MAINTENANCE OF PERSONNEL													
015	NURSING ADMINISTRATION		499,252		270				35					
016	CENTRAL SERVICES & SUPPLY		150,347		1,497									
017	PHARMACY		380,084		968									
018	MEDICAL RECORDS & LIBRARY		361,212		8,582				9					
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		1,541,004		5,571		39,072		224					100
027	ADULTS & PEDIATRICS													
028	INTENSIVE CARE UNIT													
029	CORONARY CARE UNIT													
031	BURN INTENSIVE CARE UNIT													
033	SURGICAL INTENSIVE CARE U													
034	SUBPROVIDER													
035	NURSERY													
036	01 SKILLED NURSING FACILITY													
037	NURSING FACILITY													
038	ICF/MR													
039	OTHER LONG TERM CARE													
040	ANCILLARY SRVC COST CNTRS													
041	OPERATING ROOM		778,373		2,287		16,198		69					
042	RECOVERY ROOM													
043	DELIVERY ROOM & LABOR ROO													
044	ANESTHESIOLOGY		1,537,506		1,586		13,750		40					
045	RADIOLOGY-DIAGNOSTIC													
046	RADIOLOGY-THERAPEUTIC													
047	RADIOISOTOPE													
048	LABORATORY		1,322,767		2,280				55					
049	PBP CLINICAL LAB SERVICES													
050	WHOLE BLOOD & PACKED RED													
051	BLOOD STORING, PROCESSING													
052	INTRAVENOUS THERAPY													
053	RESPIRATORY THERAPY		209,867		1,564									
054	PHYSICAL THERAPY		456,148		4,563		3,642		60					
055	OCCUPATIONAL THERAPY													
056	SPEECH PATHOLOGY		3,789											
057	ELECTROCARDIOLOGY		173,054						20					
058	ELECTROENCEPHALOGRAPHY													
060	MEDICAL SUPPLIES CHARGED		722,867											
061	DRUGS CHARGED TO PATIENTS		596,574						15					
062	RENAL DIALYSIS													
064	ASC (NON-DISTINCT PART)													
065	OUTPAT SERVICE COST CNTRS													
066	CLINIC													
067	EMERGENCY		1,322,459		4,589		30,700		198					
068	OBSERVATION BEDS (NON-DIS													
069	OTHER REIMBURS COST CNTRS													
070	HOME PROGRAM DIALYSIS													
071	AMBULANCE SERVICES		10,110		2,029									
072	DURABLE MEDICAL EQUIP-REN													
073	DURABLE MEDICAL EQUIP-SOL													
074	CORF													
075	I&R SERVICES-NOT APPRVD P													
076	HOME HEALTH AGENCY													
077	LUNG ACQUISITION													
078	SPEC PURPOSE COST CENTERS													
079	KIDNEY ACQUISITION													
080	LIVER ACQUISITION													
081	HEART ACQUISITION													
082	01 PANCREAS ACQUISITION													
083	OTHER ORGAN ACQUISITION													
084	AMBULATORY SURGICAL CENTE													
085	HOSPICE													
086	SUBTOTALS	-3,876,880	12,053,784		41,951		108,962		754					100
087	NONREIMBURS COST CENTERS													
088	GIFT, FLOWER, COFFEE SHOP		3,101		212									
089	RESEARCH													
090	PHYSICIANS' PRIVATE OFFIC													
091	01 PHYSICIANS' PRIVATE OFFIC		273,931											
092	02 CLAY COUNTY CLINIC		303,044											
093	03 MISSION SERVICES		14,810											
094	04 PUBLIC RELATIONS		115,622		50									
095	NONPAID WORKERS													

	COST CENTER DESCRIPTION	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			( ACCUM. COST )	( SQUARE FEET )	( SQUARE FEET )	( POUNDS OF LAUNDRY )	( HOURS OF SERVICE )	( MEALS SERVED )
		6a.00	6	7	8	9	10	11
100	NONREIMBURS COST CENTERS							
101	OTHER NONREIMBURSABLE COSTS		27,176		1,858			
102	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)		3,876,880		1,449,131	197,677	472,806	410,563
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)		.303083		32.881736	1.814183	627.063660	4,105.630000
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)		387,188		281,220	40,404	32,096	54,909
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)		.030269		6.381067	.370808	42.567639	549.090000

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET B-1  
 I I TO 6/30/2007 I

	COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC
		( EMPLOYEE )	( NUMBER )	( DIRECT )	( COSTED )	( COSTED )	( REVENUS )	( TIME )
		HOURS	HOUSED	NRSING HRS	REQUIS.	REQUIS.		SPENT
		12	13	14	15	16	17	18
001	GENERAL SERVICE COST CNTR							
002	OLD CAP REL COSTS-BLDG &							
003	OLD CAP REL COSTS-MVBLE E							
004	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	01 NEW CAP REL COSTS-MOB BLD							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT							
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING							
011	DIETARY							
012	CAFETERIA	8,716						
013	MAINTENANCE OF PERSONNEL							
014	NURSING ADMINISTRATION	643		4,565				
015	CENTRAL SERVICES & SUPPLY					100		
016	PHARMACY						100	
017	MEDICAL RECORDS & LIBRARY	589						36,090,219
018	SOCIAL SERVICE							
020	NONPHYSICIAN ANESTHETISTS							
021	NURSING SCHOOL							
022	I&R SERVICES-SALARY & FRI							
023	I&R SERVICES-OTHER PRGM C							
024	PARAMED ED PRGM							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	2,349		2,349				1,919,038
026	INTENSIVE CARE UNIT							
027	CORONARY CARE UNIT							
028	BURN INTENSIVE CARE UNIT							
029	SURGICAL INTENSIVE CARE U							
031	SUBPROVIDER							
033	NURSERY							
034	SKILLED NURSING FACILITY							
035	NURSING FACILITY							
035	01 ICF/MR							
036	OTHER LONG TERM CARE							
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	918		918				3,814,979
038	RECOVERY ROOM							
039	DELIVERY ROOM & LABOR ROO							
040	ANESTHESIOLOGY	85						
041	RADIOLOGY-DIAGNOSTIC	1,138						9,779,042
042	RADIOLOGY-THERAPEUTIC							
043	RADIOISOTOPE							
044	LABORATORY	869						6,980,260
045	PBP CLINICAL LAB SERVICES							
046	WHOLE BLOOD & PACKED RED							
047	BLOOD STORING, PROCESSING							
048	INTRAVENOUS THERAPY							
049	RESPIRATORY THERAPY	184						1,093,191
050	PHYSICAL THERAPY							1,811,165
051	OCCUPATIONAL THERAPY							
052	SPEECH PATHOLOGY							12,035
053	ELECTROCARDIOLOGY	260						1,283,386
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED					100		1,756,783
056	DRUGS CHARGED TO PATIENTS						100	2,698,677
057	RENAL DIALYSIS							
058	ASC (NON-DISTINCT PART)							
060	OUTPAT SERVICE COST CNTRS							
060	CLINIC							
061	EMERGENCY	1,298		1,298				4,941,663
062	OBSERVATION BEDS (NON-DIS							
064	OTHER REIMBURS COST CNTRS							
064	HOME PROGRAM DIALYSIS							
065	AMBULANCE SERVICES							
066	DURABLE MEDICAL EQUIP-REN							
067	DURABLE MEDICAL EQUIP-SOL							
069	CORF							
070	I&R SERVICES-NOT APPRVD P							
071	HOME HEALTH AGENCY							
082	LUNG ACQUISITION							
083	SPEC PURPOSE COST CENTERS							
083	KIDNEY ACQUISITION							
084	LIVER ACQUISITION							
085	HEART ACQUISITION							
085	01 PANCREAS ACQUISITION							
086	OTHER ORGAN ACQUISITION							
092	AMBULATORY SURGICAL CENTE							
093	HOSPICE							
095	SUBTOTALS	8,333		4,565		100	100	36,090,219
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
097	RESEARCH							
098	PHYSICIANS' PRIVATE OFFIC							
098	01 PHYSICIANS' PRIVATE OFFIC							
098	02 CLAY COUNTY CLINIC	328						
098	03 MISSION SERVICES	5						
098	04 PUBLIC RELATIONS	50						
099	NONPAID WORKERS							

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET B-1  
 I I TO 6/30/2007 I

	COST CENTER DESCRIPTION	CAFETERIA	MAINTENANCE O	NURSING ADMIN	CENTRAL SERVI	PHARMACY	MEDICAL RECOR	SOCIAL SERVIC
		( EMPLOYEE )	( NUMBER )	( DIRECT )	( COSTED )	( COSTED )	( REVENUS )	( TIME )
		HOURS	HOUSED	NRSING HRS	REQUIS.	REQUIS.		SPENT
		12	13	14	15	16	17	18
100	NONREIMBURS COST CENTERS							
101	OTHER NONREIMBURSABLE COS							
102	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
	COST TO BE ALLOCATED	291,896		702,926	245,139	527,111	778,250	
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER	33.489674		153.981599	2,451.390000	5,271.110000	.021564	
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	31,942		24,630	35,999	31,840	193,765	
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER	3.664754		5.395400	359.990000	318.400000	.005369	
	(WRKSHT B, PT III)							

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM C	PARAMED ED PRGM
	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )
	20	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 &					
004 01 NEW CAP REL COSTS-MVBLE E					
005 EMPLOYEE BENEFITS					
006 ADMINISTRATIVE & GENERAL					
007 MAINTENANCE & REPAIRS					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
013 MAINTENANCE OF PERSONNEL					
014 NURSING ADMINISTRATION					
015 CENTRAL SERVICES & SUPPLY					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY					
018 SOCIAL SERVICE					
020 NONPHYSICIAN ANESTHETISTS					
021 NURSING SCHOOL					
022 I&R SERVICES-SALARY & FRI					
023 I&R SERVICES-OTHER PRGM C					
024 PARAMED ED PRGM					
025 INPAT ROUTINE SRVC CNTRS					
026 ADULTS & PEDIATRICS					
027 INTENSIVE CARE UNIT					
028 CORONARY CARE UNIT					
029 BURN INTENSIVE CARE UNIT					
031 SURGICAL INTENSIVE CARE U					
033 SUBPROVIDER					
034 NURSERY					
034 SKILLED NURSING FACILITY					
035 NURSING FACILITY					
035 01 ICF/MR					
036 OTHER LONG TERM CARE					
037 ANCILLARY SRVC COST CNTRS					
038 OPERATING ROOM					
039 RECOVERY ROOM					
040 DELIVERY ROOM & LABOR ROO					
041 ANESTHESIOLOGY					
042 RADIOLOGY-DIAGNOSTIC					
043 RADIOLOGY-THERAPEUTIC					
044 RADIOISOTOPE					
045 LABORATORY					
046 PBP CLINICAL LAB SERVICES					
047 WHOLE BLOOD & PACKED RED					
048 BLOOD STORING, PROCESSING					
049 INTRAVENOUS THERAPY					
050 RESPIRATORY THERAPY					
051 PHYSICAL THERAPY					
052 OCCUPATIONAL THERAPY					
053 SPEECH PATHOLOGY					
054 ELECTROCARDIOLOGY					
055 ELECTROENCEPHALOGRAPHY					
056 MEDICAL SUPPLIES CHARGED					
057 DRUGS CHARGED TO PATIENTS					
058 RENAL DIALYSIS					
060 ASC (NON-DISTINCT PART)					
061 OUTPAT SERVICE COST CNTRS					
062 CLINIC					
064 EMERGENCY					
065 OBSERVATION BEDS (NON-DIS					
066 OTHER REIMBURS COST CNTRS					
067 HOME PROGRAM DIALYSIS					
069 AMBULANCE SERVICES					
070 DURABLE MEDICAL EQUIP-REN					
071 DURABLE MEDICAL EQUIP-SOL					
072 CORF					
070 I&R SERVICES-NOT APPRVD P					
071 HOME HEALTH AGENCY					
082 LUNG ACQUISITION					
083 SPEC PURPOSE COST CENTERS					
084 KIDNEY ACQUISITION					
085 LIVER ACQUISITION					
085 01 HEART ACQUISITION					
086 PANCREAS ACQUISITION					
092 OTHER ORGAN ACQUISITION					
093 AMBULATORY SURGICAL CENTE					
095 HOSPICE					
096 SUBTOTALS					
097 NONREIMBURS COST CENTERS					
098 GIFT, FLOWER, COFFEE SHOP					
098 RESEARCH					
098 01 PHYSICIANS' PRIVATE OFFIC					
098 02 PHYSICIANS' PRIVATE OFFIC					
098 03 CLAY COUNTY CLINIC					
098 04 MISSION SERVICES					
099 04 PUBLIC RELATIONS					
099 NONPAID WORKERS					

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	I&R SERVICES- SALARY & FRI	I&R SERVICES- OTHER PRGM	PARAMED ED PRGM
	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )	( ASSIGNED TIME )
NONREIMBURS COST CENTERS	20	21	22	23	24
100 OTHER NONREIMBURSABLE COS					
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 COST TO BE ALLOCATED (PER WRKSHT B, PART I)					
104 UNIT COST MULTIPLIER (WRKSHT B, PT I)					
105 COST TO BE ALLOCATED (PER WRKSHT B, PART II)					
106 UNIT COST MULTIPLIER (WRKSHT B, PT II)					
107 COST TO BE ALLOCATED (PER WRKSHT B, PART III)					
108 UNIT COST MULTIPLIER (WRKSHT B, PT III)					

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 ADULTS & PEDIATRICS	3,294,903		3,294,903		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,416,504		1,416,504		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY	2,847		2,847		
41	RADIOLOGY-DIAGNOSTIC	2,354,663		2,354,663		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,012,759		2,012,759		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	354,637		354,637		
50	PHYSICAL THERAPY	827,725		827,725		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	5,197		5,197		
53	ELECTROCARDIOLOGY	274,427		274,427		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,224,978		1,224,978		
56	DRUGS CHARGED TO PATIENTS	1,372,096		1,372,096		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART) OUTPAT SERVICE COST CNTRS					
60	CLINIC					
61	EMERGENCY	2,403,922		2,403,922		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	741,351		741,351		
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES	79,891		79,891		
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	16,365,900		16,365,900		
102	LESS OBSERVATION BEDS	741,351		741,351		
103	TOTAL	15,624,549		15,624,549		

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	1,919,038		1,919,038			
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	716,364	3,098,614	3,814,978	.371301	.371301	
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	1,428,368	8,350,673	9,779,041	.240787	.240787	
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	1,312,299	5,667,961	6,980,260	.288350	.288350	
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	809,512	283,679	1,093,191	.324405	.324405	
51	PHYSICAL THERAPY	521,158	1,290,007	1,811,165	.457012	.457012	
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	11,550	485	12,035	.431824	.431824	
54	ELECTROCARDIOLOGY	317,558	965,828	1,283,386	.213830	.213830	
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	844,890	911,893	1,756,783	.697285	.697285	
57	DRUGS CHARGED TO PATIENTS	1,068,524	1,630,153	2,698,677	.508433	.508433	
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	971,784	3,969,878	4,941,662	.486460	.486460	
63	OBSERVATION BEDS (NON-DIS		528,349	528,349	1.403146	1.403146	
64	OTHER REIMBURS COST CNTRS						
65	HOME PROGRAM DIALYSIS						
66	AMBULANCE SERVICES						
67	DURABLE MEDICAL EQUIP-REN						
68	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	9,921,045	26,697,520	36,618,565			
102	LESS OBSERVATION BEDS						
103	TOTAL	9,921,045	26,697,520	36,618,565			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEETPROVIDER NO:  
15-1309I PERIOD:  
I FROM 7/ 1/2006  
I TO 6/30/2007I PREPARED 11/26/2007  
I WORKSHEET C  
I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,294,903		3,294,903		
26	INTENSIVE CARE UNIT					
27	CORONARY CARE UNIT					
28	BURN INTENSIVE CARE UNIT					
29	SURGICAL INTENSIVE CARE U					
31	SUBPROVIDER					
33	NURSERY					
34	SKILLED NURSING FACILITY					
35	NURSING FACILITY					
35	01 ICF/MR					
36	OTHER LONG TERM CARE ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,416,504		1,416,504		
38	RECOVERY ROOM					
39	DELIVERY ROOM & LABOR ROO					
40	ANESTHESIOLOGY	2,847		2,847		
41	RADIOLOGY-DIAGNOSTIC	2,354,663		2,354,663		
42	RADIOLOGY-THERAPEUTIC					
43	RADIOISOTOPE					
44	LABORATORY	2,012,759		2,012,759		
45	PBP CLINICAL LAB SERVICES					
46	WHOLE BLOOD & PACKED RED					
47	BLOOD STORING, PROCESSING					
48	INTRAVENOUS THERAPY					
49	RESPIRATORY THERAPY	354,637		354,637		
50	PHYSICAL THERAPY	827,725		827,725		
51	OCCUPATIONAL THERAPY					
52	SPEECH PATHOLOGY	5,197		5,197		
53	ELECTROCARDIOLOGY	274,427		274,427		
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	1,224,978		1,224,978		
56	DRUGS CHARGED TO PATIENTS	1,372,096		1,372,096		
57	RENAL DIALYSIS					
58	ASC (NON-DISTINCT PART)					
60	OUTPAT SERVICE COST CNTRS CLINIC					
61	EMERGENCY	2,403,922		2,403,922		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	741,351		741,351		
64	HOME PROGRAM DIALYSIS					
65	AMBULANCE SERVICES	79,891		79,891		
66	DURABLE MEDICAL EQUIP-REN					
67	DURABLE MEDICAL EQUIP-SOL					
101	SUBTOTAL	16,365,900		16,365,900		
102	LESS OBSERVATION BEDS	741,351		741,351		
103	TOTAL	15,624,549		15,624,549		

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	1,919,038		1,919,038			
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	716,364	3,098,614	3,814,978	.371301	.371301	
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY						
42	RADIOLOGY-DIAGNOSTIC	1,428,368	8,350,673	9,779,041	.240787	.240787	
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	1,312,299	5,667,961	6,980,260	.288350	.288350	
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	809,512	283,679	1,093,191	.324405	.324405	
51	PHYSICAL THERAPY	521,158	1,290,007	1,811,165	.457012	.457012	
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	11,550	485	12,035	.431824	.431824	
54	ELECTROCARDIOLOGY	317,558	965,828	1,283,386	.213830	.213830	
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	844,890	911,893	1,756,783	.697285	.697285	
57	DRUGS CHARGED TO PATIENTS	1,068,524	1,630,153	2,698,677	.508433	.508433	
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	971,784	3,969,878	4,941,662	.486460	.486460	
63	OBSERVATION BEDS (NON-DIS		528,349	528,349	1.403146	1.403146	
64	OTHER REIMBURS COST CNTRS						
65	HOME PROGRAM DIALYSIS						
66	AMBULANCE SERVICES						
67	DURABLE MEDICAL EQUIP-REN						
68	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	9,921,045	26,697,520	36,618,565			
102	LESS OBSERVATION BEDS						
103	TOTAL	9,921,045	26,697,520	36,618,565			

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	1,416,504	109,350	1,307,154			1,416,504
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY	2,847	312	2,535			2,847
42	RADIOLOGY-DIAGNOSTIC	2,354,663	143,330	2,211,333			2,354,663
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,012,759	129,529	1,883,230			2,012,759
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	354,637	45,751	308,886			354,637
51	PHYSICAL THERAPY	827,725	119,127	708,598			827,725
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	5,197	180	5,017			5,197
54	ELECTROCARDIOLOGY	274,427	13,932	260,495			274,427
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	1,224,978	67,311	1,157,667			1,224,978
57	DRUGS CHARGED TO PATIENTS	1,372,096	65,026	1,307,070			1,372,096
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,403,922	194,539	2,209,383			2,403,922
63	OBSERVATION BEDS (NON-DIS	741,351		741,351			741,351
64	OTHER REIMBURS COST CNTRS						
65	HOME PROGRAM DIALYSIS						
66	AMBULANCE SERVICES	79,891	23,363	56,528			79,891
67	DURABLE MEDICAL EQUIP-REN						
68	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,070,997	911,750	12,159,247			13,070,997
102	LESS OBSERVATION BEDS	741,351		741,351			741,351
103	TOTAL	12,329,646	911,750	11,417,896			12,329,646

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	3,814,978	.371301	.371301
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	9,779,041	.240787	.240787
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	6,980,260	.288350	.288350
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	1,093,191	.324405	.324405
51	PHYSICAL THERAPY	1,811,165	.457012	.457012
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	12,035	.431824	.431824
54	ELECTROCARDIOLOGY	1,283,386	.213830	.213830
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	1,756,783	.697285	.697285
57	DRUGS CHARGED TO PATIENTS	2,698,677	.508433	.508433
58	RENAL DIALYSIS			
59	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
62	EMERGENCY	4,941,662	.486460	.486460
63	OBSERVATION BEDS (NON-DIS	528,349	1.403146	1.403146
64	OTHER REIMBURS COST CNTRS			
65	HOME PROGRAM DIALYSIS			
66	AMBULANCE SERVICES			
67	DURABLE MEDICAL EQUIP-REN			
68	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	34,699,527		
102	LESS OBSERVATION BEDS	528,349		
103	TOTAL	34,171,178		

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR ST. VINCENT CLAY HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 15-1309  
 I \*\*NOT A CMS WORKSHEET \*\*  
 I PERIOD: FROM 7/1/2006 TO 6/30/2007  
 I PREPARED 11/26/2007  
 I WORKSHEET C  
 I PART II

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	1,416,504	109,350	1,307,154			1,416,504
39	RECOVERY ROOM						
40	DELIVERY ROOM & LABOR ROO						
41	ANESTHESIOLOGY	2,847	312	2,535			2,847
42	RADIOLOGY-DIAGNOSTIC	2,354,663	143,330	2,211,333			2,354,663
43	RADIOLOGY-THERAPEUTIC						
44	RADIOISOTOPE						
45	LABORATORY	2,012,759	129,529	1,883,230			2,012,759
46	PBP CLINICAL LAB SERVICES						
47	WHOLE BLOOD & PACKED RED						
48	BLOOD STORING, PROCESSING						
49	INTRAVENOUS THERAPY						
50	RESPIRATORY THERAPY	354,637	45,751	308,886			354,637
51	PHYSICAL THERAPY	827,725	119,127	708,598			827,725
52	OCCUPATIONAL THERAPY						
53	SPEECH PATHOLOGY	5,197	180	5,017			5,197
54	ELECTROCARDIOLOGY	274,427	13,932	260,495			274,427
55	ELECTROENCEPHALOGRAPHY						
56	MEDICAL SUPPLIES CHARGED	1,224,978	67,311	1,157,667			1,224,978
57	DRUGS CHARGED TO PATIENTS	1,372,096	65,026	1,307,070			1,372,096
58	RENAL DIALYSIS						
59	ASC (NON-DISTINCT PART)						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
62	EMERGENCY	2,403,922	194,539	2,209,383			2,403,922
63	OBSERVATION BEDS (NON-DIS	741,351		741,351			741,351
64	OTHER REIMBURS COST CNTRS						
65	HOME PROGRAM DIALYSIS						
66	AMBULANCE SERVICES	79,891	23,363	56,528			79,891
67	DURABLE MEDICAL EQUIP-REN						
68	DURABLE MEDICAL EQUIP-SOL						
101	SUBTOTAL	13,070,997	911,750	12,159,247			13,070,997
102	LESS OBSERVATION BEDS	741,351		741,351			741,351
103	TOTAL	12,329,646	911,750	11,417,896			12,329,646

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
38	OPERATING ROOM	3,814,978	.371301	.371301
39	RECOVERY ROOM			
40	DELIVERY ROOM & LABOR ROO			
41	ANESTHESIOLOGY			
42	RADIOLOGY-DIAGNOSTIC	9,779,041	.240787	.240787
43	RADIOLOGY-THERAPEUTIC			
44	RADIOISOTOPE			
45	LABORATORY	6,980,260	.288350	.288350
46	PBP CLINICAL LAB SERVICES			
47	WHOLE BLOOD & PACKED RED			
48	BLOOD STORING, PROCESSING			
49	INTRAVENOUS THERAPY			
50	RESPIRATORY THERAPY	1,093,191	.324405	.324405
51	PHYSICAL THERAPY	1,811,165	.457012	.457012
52	OCCUPATIONAL THERAPY			
53	SPEECH PATHOLOGY	12,035	.431824	.431824
54	ELECTROCARDIOLOGY	1,283,386	.213830	.213830
55	ELECTROENCEPHALOGRAPHY			
56	MEDICAL SUPPLIES CHARGED	1,756,783	.697285	.697285
57	DRUGS CHARGED TO PATIENTS	2,698,677	.508433	.508433
58	RENAL DIALYSIS			
59	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC			
62	EMERGENCY	4,941,662	.486460	.486460
63	OBSERVATION BEDS (NON-DIS	528,349	1.403146	1.403146
64	OTHER REIMBURS COST CNTRS			
65	HOME PROGRAM DIALYSIS			
66	AMBULANCE SERVICES			
67	DURABLE MEDICAL EQUIP-REN			
68	DURABLE MEDICAL EQUIP-SOL			
101	SUBTOTAL	34,699,527		
102	LESS OBSERVATION BEDS	528,349		
103	TOTAL	34,171,178		

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	.371301		.371301		
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC	.240787		.240787		
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY	.288350		.288350		
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	.324405		.324405		
50 PHYSICAL THERAPY	.457012		.457012		
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY	.431824		.431824		
53 ELECTROCARDIOLOGY	.213830		.213830		
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.697285		.697285		
56 DRUGS CHARGED TO PATIENTS	.508433		.508433		
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY	.486460		.486460		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.403146		1.403146		
64 OTHER REIMBURS COST CNTRS					
64 HOME PROGRAM DIALYSIS					
65 AMBULANCE SERVICES					
66 DURABLE MEDICAL EQUIP-RENTED					
67 DURABLE MEDICAL EQUIP-SOLD					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

All Other Hospital I/P Hospital I/P  
 Part B Charges Part B Costs

Cost Center Description 9 10 11

(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	498,909		
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	682,919		
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	642,779		
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	92,027		
50	PHYSICAL THERAPY	208,484		
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	31,268		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	599,001		
56	DRUGS CHARGED TO PATIENTS	565,813		
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	587,083		
62	OBSERVATION BEDS (NON-DISTINCT PART)	432,151		
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	SUBTOTAL	4,340,434		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	4,340,434		

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/26/2007
I	15-1309	I	FROM 7/ 1/2006	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2007	I	PART VI
I	15-1309	I		I	

TITLE XVIII, PART B

HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1
2	PROGRAM VACCINE CHARGES	.508433
3	PROGRAM COSTS	8,391
		4,266

## COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/26/2007
I	15-1309	I	FROM 7/ 1/2006	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 6/30/2007	I	PART I
I	15-1309	I		I	

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)	4,678
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,488
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	8
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,480
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	552
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)	553
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	43
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)	42
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,712
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	552
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)	553
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	3,294,903
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	5,641
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	5,739
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	801,345
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,493,558

## PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,919,038
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,919,038
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.299379
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	551.45
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	2,493,558

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

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					714.90
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,223,909
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,223,909

	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				
49	TOTAL PROGRAM INPATIENT COSTS				

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)	394,625
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	395,340
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	789,965
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	

COMPUTATION OF INPATIENT OPERATING COST

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	1,037
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	714.90
85	OBSERVATION BED COST	741,351

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)	4,678
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,488
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	3,488
6	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	1,105
7	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	
8	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	85
9	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	167
10	(EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	
11	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	
12	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
12	YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING	
13	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	
14	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
14	YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	
15	(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	
18	DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER	
19	DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH	
20	DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER	
21	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	
23	REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
24	REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST	
25	REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
26	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)	1,919,038
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,919,038
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	550.18
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 HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					1,465,221

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 1,465,221

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES 60  
 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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2007 I PART III  
 I 15-1309 I I

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	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,037
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.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL RATIO COST TO CHARGES 1	OTHER INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,110,699	
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	.371301	317,562	117,911
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.240787	385,004	92,704
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.288350	512,775	147,859
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	.324405	343,762	111,518
50	PHYSICAL THERAPY	.457012	91,179	41,670
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	.431824	7,957	3,436
53	ELECTROCARDIOLOGY	.213830	31,492	6,734
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.697285	487,932	340,228
56	DRUGS CHARGED TO PATIENTS	.508433	542,148	275,646
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
60	OUTPAT SERVICE COST CNTRS CLINIC			
61	EMERGENCY	.486460	7,898	3,842
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.403146		
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		2,727,709	1,141,548
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,727,709	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2007 I  
 I 15-2309 I

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	.371301	6,686	2,483
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.240787	56,098	13,508
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.288350	90,262	26,027
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	.324405	107,394	34,839
50	PHYSICAL THERAPY	.457012	249,423	113,989
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	.431824	2,234	965
53	ELECTROCARDIOLOGY	.213830	2,546	544
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.697285	110,029	76,722
56	DRUGS CHARGED TO PATIENTS	.508433	254,033	129,159
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.486460		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.403146		
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		878,705	398,236
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		878,705	

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			
26	ADULTS & PEDIATRICS		179,592	
27	INTENSIVE CARE UNIT			
28	CORONARY CARE UNIT			
29	BURN INTENSIVE CARE UNIT			
31	SURGICAL INTENSIVE CARE UNIT			
	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.371301	392,116	145,593
38	RECOVERY ROOM			
39	DELIVERY ROOM & LABOR ROOM			
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	.240787	987,266	237,721
42	RADIOLOGY-THERAPEUTIC			
43	RADIOISOTOPE			
44	LABORATORY	.288350	709,262	204,516
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	.324405	123,634	40,107
50	PHYSICAL THERAPY	.457012	180,556	82,516
51	OCCUPATIONAL THERAPY			
52	SPEECH PATHOLOGY	.431824		
53	ELECTROCARDIOLOGY	.213830	41,059	8,780
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.697285	246,929	172,180
56	DRUGS CHARGED TO PATIENTS	.508433	206,352	104,916
57	RENAL DIALYSIS			
58	ASC (NON-DISTINCT PART)			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC			
61	EMERGENCY	.486460	963,886	468,892
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.403146		
	OTHER REIMBURS COST CNTRS			
64	HOME PROGRAM DIALYSIS			
65	AMBULANCE SERVICES			
66	DURABLE MEDICAL EQUIP-RENTED			
67	DURABLE MEDICAL EQUIP-SOLD			
101	TOTAL		3,851,060	1,465,221
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		3,851,060	

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/26/2007
I	15-1309	I	FROM 7/ 1/2006	I	WORKSHEET E
I	COMPONENT NO:	I	TO 6/30/2007	I	PART B
I	15-1309	I		I	

## PART B - MEDICAL AND OTHER HEALTH SERVICES

## HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,344,700
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)	4,344,700
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)	4,388,147
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	35,661
18.01	CAH ACTUAL BILLED COINSURANCE	1,722,296
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,630,190
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	2,630,190
24	PRIMARY PAYER PAYMENTS	2,080
25	SUBTOTAL	2,628,110
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	291,935
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	291,935
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	266,195
28	SUBTOTAL	2,920,045
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,920,045
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,390,420
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	529,625
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 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,800,205		2,489,583
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		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM	2/15/2007	71,918	2/15/2007	99,163
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
ADJUSTMENTS TO PROGRAM		.99		
SUBTOTAL		-71,918		-99,163
4 TOTAL INTERIM PAYMENTS		1,728,287		2,390,420
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)		.01		
BASED ON COST REPORT (1)		.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.

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS  
 PROVIDER NO: 15-1309 PERIOD: FROM 7/1/2006 TO 6/30/2007  
 COMPONENT NO: 15-1309  
 PREPARED 11/26/2007 WORKSHEET D PART V

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		1,343,679			
38 RECOVERY ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		2,836,195			
42 RADIOLOGY-THERAPEUTIC					
43 RADIOISOTOPE					
44 LABORATORY		2,229,161			
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		283,679			
50 PHYSICAL THERAPY		456,190			
51 OCCUPATIONAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY		146,229			
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		859,047			
56 DRUGS CHARGED TO PATIENTS		1,112,857			
57 RENAL DIALYSIS					
58 ASC (NON-DISTINCT PART)					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
62 EMERGENCY		1,206,847			
OBSERVATION BEDS (NON-DISTINCT PART)		307,987			
64 OTHER REIMBURS COST CNTRS					
65 HOME PROGRAM DIALYSIS					
66 AMBULANCE SERVICES					
67 DURABLE MEDICAL EQUIP-RENTED					
101 DURABLE MEDICAL EQUIP-SOLD					
102 SUBTOTAL		10,781,871			
103 CRNA CHARGES					
104 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
NET CHARGES		10,781,871			

(A) WORKSHEET A LINE NUMBERS

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

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		1,027,241		
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	2/15/2007	1,642		
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		1,642		NONE
4 TOTAL INTERIM PAYMENTS		1,028,883		
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.

CALCULATION OF REIMBURSEMENT SETTLEMENT  
SWING BEDS

I PROVIDER NO: I PERIOD: I IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)  
 I 15-1309 I FROM 7/ 1/2006 I PREPARED 11/26/2007  
 I COMPONENT NO: I TO 6/30/2007 I WORKSHEET E-2  
 I 15-Z309 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	797,865	
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3 ANCILLARY SERVICES (SEE INSTRUCTIONS)	402,218	
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5 PROGRAM DAYS	1,105	
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8 SUBTOTAL	1,200,083	
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10 SUBTOTAL	1,200,083	
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12 SUBTOTAL	1,200,083	
13 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	7,037	
14 80% OF PART B COSTS		
15 SUBTOTAL	1,193,046	
16 OTHER ADJUSTMENTS (SPECIFY)		
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL	1,193,046	
19 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20 INTERIM PAYMENTS	1,028,883	
20.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21 BALANCE DUE PROVIDER/PROGRAM	164,163	
22 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/26/2007  
 I 15-1309 I FROM 7/ 1/2006 I WORKSHEET E-3  
 I COMPONENT NO: I TO 6/30/2007 I PART II  
 I 15-1309 I I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,365,457
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,365,457
5	PRIMARY PAYER PAYMENTS	5,349
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,383,709
	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	2,383,709
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	340,726
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,042,983
23	COINSURANCE	
24	SUBTOTAL	2,042,983
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	42,988
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	42,988
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	38,580
26	SUBTOTAL	2,085,971
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	2,085,971
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,728,287
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	357,684
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)			
24	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
25	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
26	COST OF COVERED SERVICES			
27	PROSPECTIVE PAYMENT AMOUNT			
28	OTHER THAN OUTLIER PAYMENTS			
29	OUTLIER PAYMENTS			
30	PROGRAM CAPITAL PAYMENTS			
31	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
32	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
33	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
34	SUBTOTAL			
35	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
36	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE			
37	XVIII ENTER AMOUNT FROM LINE 30			
38	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
39	EXCESS OF REASONABLE COST			
40	SUBTOTAL			
41	COINSURANCE			
42	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
43	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
44	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
45	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
46	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
47	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
48	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
49	UTILIZATION REVIEW			
50	SUBTOTAL (SEE INSTRUCTIONS)			
51	INPATIENT ROUTINE SERVICE COST			
52	MEDICARE INPATIENT ROUTINE CHARGES			
53	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
54	PAYMENT FOR SERVICES ON A CHARGE BASIS			
55	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
56	FOR PAYMENT OF PART A SERVICES			
57	RATIO OF LINE 43 TO 44			
58	TOTAL CUSTOMARY CHARGES			
59	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
60	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
61	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
62	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
63	OTHER ADJUSTMENTS (SPECIFY)			
64	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
65	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
66	SUBTOTAL			
67	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
68	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
69	TOTAL AMOUNT PAYABLE TO THE PROVIDER			
70	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
71	INTERIM PAYMENTS			
72	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
73	BALANCE DUE PROVIDER/PROGRAM			
74	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			
75	IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.			

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,502,952			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	6,086,892			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,716,303			
7	INVENTORY	575,495			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS	-39,349			
10	DUE FROM OTHER FUNDS	1,097,416			
11	TOTAL CURRENT ASSETS	9,507,103			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS	320,447			
13	LESS ACCUMULATED DEPRECIATION	-272,697			
14	BUILDINGS	8,932,344			
14.01	LESS ACCUMULATED DEPRECIATION	-2,530,410			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	2,349,084			
16.01	LESS ACCUMULATED DEPRECIATION	-1,949,423			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	6,559,561			
18.01	LESS ACCUMULATED DEPRECIATION	-4,797,470			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	8,611,436			
OTHER ASSETS					
22	INVESTMENTS	3,939,712	1,003,442		
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS				
26	TOTAL OTHER ASSETS	3,939,712	1,003,442		
27	TOTAL ASSETS	22,058,251	1,003,442		

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	529,138			
29 SALARIES, WAGES & FEES PAYABLE	804,663			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	148,536			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS	50,676			
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	213,419			
36 TOTAL CURRENT LIABILITIES	1,746,432			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	8,372,309			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	381,659			
42 TOTAL LONG-TERM LIABILITIES	8,753,968			
43 TOTAL LIABILITIES	10,500,400			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	11,557,851			
45 SPECIFIC PURPOSE FUND		1,003,442		
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	11,557,851	1,003,442		
52 TOTAL LIABILITIES AND FUND BALANCES	22,058,251	1,003,442		

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER NO: 15-1309  
 PERIOD: FROM 7/1/2006 TO 6/30/2007  
 PREPARED 11/26/2007  
 WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		9,184,987		939,240
2 NET INCOME (LOSS)		2,425,571		
3 TOTAL		11,610,558		939,240
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 CONTRIBUTIONS	5,500		25,313	
6 RESTRICTED INVESTMENT INC			86,553	
7 GRANT REVENUE			11,873	
8 UNREALIZED GAIN/LOSS ON I			22,079	
9				
10 TOTAL ADDITIONS	5,500			145,818
11 SUBTOTAL		11,616,058		1,085,058
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM			81,616	
14 OTHER UNRESTRICTED ACTIVI	58,207			
15				
16				
17				
18 TOTAL DEDUCTIONS		58,207		81,616
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		11,557,851		1,003,442

	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 CONTRIBUTIONS				
6 RESTRICTED INVESTMENT INC				
7 GRANT REVENUE				
8 UNREALIZED GAIN/LOSS ON I				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 NET ASSETS RELEASED FROM				
14 OTHER UNRESTRICTED ACTIVI				
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
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL			
2 00 SUBPROVIDER	1,919,038		1,919,038
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY			
7 00 NURSING FACILITY			
7 01 ICF/MR			
8 00 OTHER LONG TERM CARE			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,919,038		1,919,038
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT			
11 00 CORONARY CARE UNIT			
12 00 BURN INTENSIVE CARE UNIT			
13 00 SURGICAL INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,919,038		1,919,038
17 00 ANCILLARY SERVICES	5,232,857	30,106,509	35,339,366
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY			
20 00 AMBULANCE SERVICES			
21 00 CORF			
22 00 AMBULATORY SURGICAL CENTER (D.P.)			
23 00 HOSPICE			
24 00			
25 00 TOTAL PATIENT REVENUES	7,151,895	30,106,509	37,258,404

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		15,991,712	
ADD (SPECIFY)			
27 00 BAD DEBTS	2,992,089		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,992,089	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		18,983,801	

## STATEMENT OF REVENUES AND EXPENSES

PROVIDER NO:	I PERIOD:	I	PREPARED 11/26/2007
15-1309	I FROM 7/ 1/2006	I	WORKSHEET G-3
	I TO 6/30/2007	I	

DESCRIPTION		
1	TOTAL PATIENT REVENUES	37,258,404
2	LESS: ALLOWANCES AND DISCOUNTS ON	16,508,545
3	NET PATIENT REVENUES	20,749,859
4	LESS: TOTAL OPERATING EXPENSES	18,983,801
5	NET INCOME FROM SERVICE TO PATIENT	1,766,058
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	355,999
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	37,351
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	12,030
18	REVENUE FROM SALE OF MEDICAL REC	4,602
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	135,533
23	GOVERNMENTAL APPROPRIATIONS	
24	MISCELLANEOUS OPERATING INCOME	6,898
24.02	NET ASSETS RELEASED FROM RESTRICT	76,116
24.03	UNREALIZED GAINS/LOSSES	30,984
24.04		
24.05		
24.06		
24.07		
24.08		
25	TOTAL OTHER INCOME	659,513
26	TOTAL	2,425,571
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	2,425,571