

WORKSHEET 5
 PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	15-1320	I	FROM 10/ 1/2006	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 9/30/2007	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 2/27/2008 TIME 14:43

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:
 JAY COUNTY HOSPITAL 15-1320
 FOR THE COST REPORTING PERIOD BEGINNING 10/ 1/2006 AND ENDING 9/30/2007 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.



OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

 ECR ENCRYPTION INFORMATION
 DATE: 2/27/2008 TIME 14:43

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 SqTU00yEjw1jLjfskysRQUTJ40TTtg
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 Rorr86z5y20eGzvm

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
	1	2		3	4
1	HOSPITAL	0	24,702	117,603	1,270,212
2	SUBPROVIDER	0	0	0	0
3	SWING BED - SNF	0	-56,133	0	0
100	TOTAL	0	-31,431	117,603	1,270,212

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: 500 W. VOTAN P.O. BOX:
 1.01 CITY: PORTLAND STATE: IN ZIP CODE: 47371- COUNTY: JAY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P, T, O OR N)
02.00 HOSPITAL	JAY COUNTY HOSPITAL	15-1320	2.01	1/ 1/2004	4 5 6
03.00 SUBPROVIDER	JAY COUNTY HOSPITAL-PSYCH UNIT	15-M320		10/ 1/2005	N O O
04.00 SWING BED - SNF	JAY COUNTY HOSPITAL	15-2320		1/ 1/2004	N P N
					N O O

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 10/ 1/2006 TO: 9/30/2007

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER 4

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. N
- 25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N
- 25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)
- 25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)
- 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
- 26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: // / ENDING: // /
- 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: // / ENDING: // /
- 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 1/ 1/2004

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02
 28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4
 28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 0 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)

28.03 STAFFING % Y/N
 28.04 RECRUITMENT 0.00%
 28.05 RETENTION 0.00%
 28.06 TRAINING 0.00%
 29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N
 30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N
 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
 31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) V XVIII XIX
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS) 1 2 3
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
- 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? Y
- 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 N
- 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? Y
- 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
- 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	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N
48.00 SUBPROVIDER	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: 0
 - PAID LOSSES: 0
 - AND/OR SELF INSURANCE: 0
- 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
- 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N
- 56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
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.	10/1/2006	N	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) Y Y
- 60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	7,665	183,960.00			1,530	295
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						1,375	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	7,665				2,905	295
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	25	7,665				2,905	295
13 RPCH VISITS							
14 SUBPROVIDER	10	3,650				2,279	
25 TOTAL	35						
26 OBSERVATION BED DAYS							
26 01 OBSERVATION BED DAYS-SUB I							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS TOTAL ADMITTED 6.01	OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			2,730				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,482				
4 ADULTS & PED-SB NF			62				
5 TOTAL ADULTS AND PEDS			4,274				
6 INTENSIVE CARE UNIT							
11 NURSERY			178				
12 TOTAL			4,452				
13 RPCH VISITS							
14 SUBPROVIDER			2,467				
25 TOTAL							
26 OBSERVATION BED DAYS			564	54	510		
26 01 OBSERVATION BED DAYS-SUB I							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					456	109	999
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		189.74			456	109	999
13 RPCH VISITS							
14 SUBPROVIDER		14.26			181		197
25 TOTAL		204.00					
26 OBSERVATION BED DAYS							
26 01 OBSERVATION BED DAYS-SUB I							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 15-1320
II PERIOD:
I FROM 10/ 1/2006
I TO 9/30/2007I PREPARED 2/27/2008
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		1,140,297	1,140,297		1,140,297
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP MOB					
4.02	0402 NEW CAP REL COSTS-MVBLE EQUIP-POB					
5	0500 EMPLOYEE BENEFITS		2,495,470	2,495,470		2,495,470
6	0600 ADMINISTRATIVE & GENERAL	1,315,229	4,414,172	5,729,401		5,729,401
8	0800 OPERATION OF PLANT	271,839	644,446	916,285		916,285
8.01	0801 OPERATION OF PLANT-MOB					
8.02	0802 OPERATION OF PLANT-POB					
9	0900 LAUNDRY & LINEN SERVICE	37,981	25,326	63,307		63,307
10	1000 HOUSEKEEPING	217,209	54,858	272,067		272,067
11	1100 DIETARY	289,309	182,162	471,471	-137,729	333,742
12	1200 CAFETERIA				137,729	137,729
14	1400 NURSING ADMINISTRATION	698,497	80,237	778,734		778,734
15	1500 CENTRAL SERVICES & SUPPLY	60,941	173,792	234,733		234,733
17	1700 MEDICAL RECORDS & LIBRARY	279,098	106,835	385,933		385,933
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,435,748	145,369	1,581,117	-150,635	1,430,482
26	2600 INTENSIVE CARE UNIT					
31	3100 SUBPROVIDER	485,095	465,098	950,193		950,193
33	3300 NURSERY				132,439	132,439
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	658,486	683,690	1,342,176		1,342,176
39	3900 DELIVERY ROOM & LABOR ROOM				18,196	18,196
40	4000 ANESTHESIOLOGY	226,734	524,475	751,209		751,209
41	4100 RADIOLOGY-DIAGNOSTIC	606,132	736,897	1,343,029		1,343,029
44	4400 LABORATORY	458,092	823,881	1,281,973		1,281,973
49	4900 RESPIRATORY THERAPY		293,035	293,035		293,035
50	5000 PHYSICAL THERAPY		433,927	433,927		433,927
52	5200 SPEECH PATHOLOGY					
53	5300 ELECTROCARDIOLOGY	58,512	24,820	83,332		83,332
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600 DRUGS CHARGED TO PATIENTS	309,608	859,073	1,168,681		1,168,681
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	585,697	516,892	1,102,589		1,102,589
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	6300 OTHER OUTPATIENT SERVICE COST CENTER	82,115	91,246	173,361		173,361
	SPEC PURPOSE COST CENTERS					
85	8500 HEART ACQUISITION					
88	8800 INTEREST EXPENSE					
95	9500 SUBTOTALS	8,076,322	14,915,998	22,992,320	-0-	22,992,320
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES					
99	9900 NONPAID WORKERS					
100	10000 OTHER NONREIMBURSABLE COST CENTERS		5,900	5,900		5,900
100.01	7951 ORTHO		5,175	5,175		5,175
100.02	7952 WEST JAY CLINIC		286,435	286,435		286,435
101	TOTAL	8,076,322	15,213,508	23,289,830	-0-	23,289,830

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
I 15-1320 I FROM 10/ 1/2006 I WORKSHEET A
I I TO 9/30/2007 I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
4	0400 NEW CAP REL COSTS-MVBLE EQUIP	-3,996	1,136,301
4.01	0401 NEW CAP REL COSTS-MVBLE EQUIP MOB		
4.02	0402 NEW CAP REL COSTS-MVBLE EQUIP-POB		
5	0500 EMPLOYEE BENEFITS	-47,040	2,448,430
6	0600 ADMINISTRATIVE & GENERAL	-2,950,705	2,778,696
8	0800 OPERATION OF PLANT	-23,016	893,269
8.01	0801 OPERATION OF PLANT-MOB		
8.02	0802 OPERATION OF PLANT-POB		
9	0900 LAUNDRY & LINEN SERVICE		63,307
10	1000 HOUSEKEEPING		272,067
11	1100 DIETARY		333,742
12	1200 CAFETERIA	-59,826	77,903
14	1400 NURSING ADMINISTRATION	-12,453	766,281
15	1500 CENTRAL SERVICES & SUPPLY		234,733
17	1700 MEDICAL RECORDS & LIBRARY	-8,299	377,634
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-8,000	1,422,482
26	2600 INTENSIVE CARE UNIT		
31	3100 SUBPROVIDER		950,193
33	3300 NURSERY		132,439
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-88,500	1,253,676
39	3900 DELIVERY ROOM & LABOR ROOM		18,196
40	4000 ANESTHESIOLOGY	-540,367	210,842
41	4100 RADIOLOGY-DIAGNOSTIC		1,343,029
44	4400 LABORATORY	-60,000	1,221,973
49	4900 RESPIRATORY THERAPY		293,035
50	5000 PHYSICAL THERAPY		433,927
52	5200 SPEECH PATHOLOGY		
53	5300 ELECTROCARDIOLOGY		83,332
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	5600 DRUGS CHARGED TO PATIENTS	-88,126	1,080,555
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY		1,102,589
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		173,361
	SPEC PURPOSE COST CENTERS		
85	8500 HEART ACQUISITION		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-3,890,328	19,101,992
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		
99	9900 NONPAID WORKERS		
100	7950 OTHER NONREIMBURSABLE COST CENTERS		5,900
100.01	7951 ORTHO		5,175
100.02	7952 WEST JAY CLINIC		286,435
101	TOTAL	-3,890,328	19,399,502

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I NOT A CMS WORKSHEET
 I I TO 9/30/2007 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
4.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	0401	NEW CAP REL COSTS-MVBLE EQUIP
4.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	0402	NEW CAP REL COSTS-MVBLE EQUIP
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
8.01	OPERATION OF PLANT-MOB	0801	OPERATION OF PLANT
8.02	OPERATION OF PLANT-POB	0802	OPERATION OF PLANT
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
31	SUBPROVIDER	3100	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
	SPEC PURPOSE COST CE		
85	HEART ACQUISITION	8500	
88	INTEREST EXPENSE	8800	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
99	NONPAID WORKERS	9900	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	ORTHO	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	WEST JAY CLINIC	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 2	INCREASE		SALARY 4	OTHER 5
			LINE NO 3			
1 NURSERY RECLASS	A	NURSERY	33		121,295	11,144
2 LABOR & DELIVERY RECLASS	B	DELIVERY ROOM & LABOR ROOM	39		16,665	1,531
3 CAFETERIA RECLASS	D	CAFETERIA	12		84,515	53,214
36 TOTAL RECLASSIFICATIONS					222,475	65,889

(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.

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO				
	1	6		7	8	9	
1 NURSERY RECLASS	A	ADULTS & PEDIATRICS	25		121,295	11,144	
2 LABOR & DELIVERY RECLASS	B	ADULTS & PEDIATRICS	25		16,665	1,531	
3 CAFETERIA RECLASS	D	DIETARY	11		84,515	53,214	
36 TOTAL RECLASSIFICATIONS					222,475	65,889	

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

RECLASS CODE: A
 EXPLANATION : NURSERY RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	NURSERY	132,439	33	ADULTS & PEDIATRICS	132,439
TOTAL RECLASSIFICATIONS FOR CODE A					132,439

RECLASS CODE: B
 EXPLANATION : LABOR & DELIVERY RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	DELIVERY ROOM & LABOR ROOM	18,196	39	ADULTS & PEDIATRICS	18,196
TOTAL RECLASSIFICATIONS FOR CODE B					18,196

RECLASS CODE: D
 EXPLANATION : CAFETERIA RECLASS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	137,729	12	DIETARY	137,729
TOTAL RECLASSIFICATIONS FOR CODE D					137,729

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	220,245					220,245	
2 LAND IMPROVEMENTS	825,008					825,008	
3 BUILDINGS & FIXTURE	13,856,033	540,972		540,972		14,397,005	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	1,798,809	45,168		45,168		1,843,977	
6 MOVABLE EQUIPMENT	4,999,133	697,605		697,605		5,696,738	
7 SUBTOTAL	21,699,228	1,283,745		1,283,745		22,982,973	
8 RECONCILING ITEMS							
9 TOTAL	21,699,228	1,283,745		1,283,745		22,982,973	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS		RATIO 4	ALLOCATION OF OTHER CAPITAL			TOTAL 8
		CAPITLIZED LEASES 2	GROSS ASSETS FOR RATIO 3		INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
* NEW CAP REL COSTS-MV								
4 01 NEW CAP REL COSTS-MV								
4 02 NEW CAP REL COSTS-MV								
5 TOTAL				1.000000				

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
* NEW CAP REL COSTS-MV							
4 01 NEW CAP REL COSTS-MV	1,136,301						1,136,301
4 02 NEW CAP REL COSTS-MV							
5 TOTAL	1,136,301						1,136,301

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

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1) 15
	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
* NEW CAP REL COSTS-MV							
4 01 NEW CAP REL COSTS-MV	1,140,297						1,140,297
4 02 NEW CAP REL COSTS-MV							
5 TOTAL	1,140,297						1,140,297

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I
I 15-1320 I
I I

IN LIEU OF FORM CMS-2552-96(05/1999)
I PERIOD: I PREPARED 2/27/2008
I FROM 10/ 1/2006 I WORKSHEET A-8
I TO 9/30/2007 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER	LINE NO	
	1	2	3	4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-156,500			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS					
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS					
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			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34 PHYSICIANS ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37 CAFETERIA SALES	B	-59,826	CAFETERIA	12	
38 MEDICAL RECORDS FEES	B	-5,653	MEDICAL RECORDS & LIBRARY	17	
39 JEMS RENTAL	B	-6,000	ADMINISTRATIVE & GENERAL	6	
40 XEROX COPIES	B	-50	ADMINISTRATIVE & GENERAL	6	
41 SUPPLY REBATES AND DISCOUNTS	B	-22,718	ADMINISTRATIVE & GENERAL	6	
42 OTHER REVENUE	B	-8,661	ADMINISTRATIVE & GENERAL	6	
43 CRNA OFFSET	A	-540,367	ANESTHESIOLOGY	40	
44 PHYSICIAN RECRUITMENT	A	-186,162	ADMINISTRATIVE & GENERAL	6	
45 ADVERTISING EXPENSE	A	-50,872	ADMINISTRATIVE & GENERAL	6	
46 SENIOR PROGRAM	A	-17,263	ADMINISTRATIVE & GENERAL	6	
47 SWITCHBOARD SALARY	A	-6,397	ADMINISTRATIVE & GENERAL	6	
48 SWITCHBOARD EH&W	A	-2,085	EMPLOYEE BENEFITS	5	
49 PAT TELEPHONE EXPENSE	A	-15,598	ADMINISTRATIVE & GENERAL	6	
49.01 PAT TELEPHONE DEPRECIATION	A	-3,996	NEW CAP REL COSTS-MVBLE E	4	9
49.02 HEALTH EDUCATION	B	-37,210	ADMINISTRATIVE & GENERAL	6	
49.03 DEFAULT REVENUE	B	-7,193	ADMINISTRATIVE & GENERAL	6	
49.04 PHARMACY EMPLOYEE SALES	B	-88,126	DRUGS CHARGED TO PATIENTS	56	
49.05 MANAGEMENT FEES	B	-16,250	ADMINISTRATIVE & GENERAL	6	
49.06 BAD DEBT EXPENSE	A	-2,475,399	ADMINISTRATIVE & GENERAL	6	
49.07 MAINTENANCE WAGES	A	-23,016	OPERATION OF PLANT	8	
49.08 ADMINISTRATIVE WAGES	A	-100,932	ADMINISTRATIVE & GENERAL	6	
49.09 MEDICAL RECORDS WAGES	A	-2,646	MEDICAL RECORDS & LIBRARY	17	
49.10 PENSION ADJUSTMENT	A	-44,955	EMPLOYEE BENEFITS	5	
49.11 DIABETIC COUNSELING	A	-12,453	NURSING ADMINISTRATION	14	
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,890,328			

(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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I IN LIEU OF FORM CMS-2552-96(9/1996)
 I 15-1320 I FROM 10/ 1/2006 I PREPARED 2/27/2008
 I I TO 9/30/2007 I WORKSHEET A-8-2
 I GROUP 1

1	2	3	4	5	6	7	8	9
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	44 LAB	60,000	60,000					
2	61 ER	399,804		399,804				
3	25 OB	8,000	8,000					
4	37 SURGERY	88,500	88,500					
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	556,304	156,500	399,804				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I IN LIEU OF FORM CMS-2552-96(9/1996)
 I 15-1320 I PERIOD: I PREPARED 2/27/2008
 I FROM 10/ 1/2006 I WORKSHEET A-8-2
 I TO 9/30/2007 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	LAB							
2 61	ER							60,000
3 25	OB							8,000
4 37	SURGERY							88,500
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							156,500

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

I PROVIDER NO:
I 15-1320

I PERIOD:
I FROM 10/ 1/2006
I TO 9/30/2007

I PREPARED 2/27/2008
I WORKSHEET A-8-4
I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 52
(SEE INSTRUCTIONS)
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)
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		7090.00			
10 AHSEA (SEE INSTRUCTIONS)		62.16			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	31.08	31.08			
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) 440,714
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) 440,714
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) 440,714

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) 440,714

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

I PROVIDER NO: I 15-1320 I

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)					
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)	440,714
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)	440,714
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	407,721
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)	407,721
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)	407,721
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL

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

I PROVIDER NO:
I 15-1320
I

IN LIEU OF FORM CMS-2552-96(12/1999)
I PERIOD: I PREPARED 2/27/2008
I FROM 10/ 1/2006 I WORKSHEET A-8-4
I TO 9/30/2007 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)

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

I PROVIDER NO: I 15-1320 I

IN LIEU OF FORM CMS-2552-96(12/1999) I PERIOD: I PREPARED 2/27/2008 I FROM 10/ 1/2006 I WORKSHEET A-8-4 I TO 9/30/2007 I PARTS I - VII

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 52
 (SEE INSTRUCTIONS)
 2 LINE 1 MULTIPLIED BY 15 HOURS PER WEEK 780
 3 NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE 365
 (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		5019.00		2452.00	
10 AHSEA (SEE INSTRUCTIONS)		50.51		37.88	
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	25.26	25.26			
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) 253,510
 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) 253,510
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10) 92,882
 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) 346,392

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) 346,392

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) 9,220
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 9,220
 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) 9,220
 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE
 29 THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
 30 ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
 31 SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)
 32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 9,220
 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

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
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 CALCULATION OF LIMIT 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 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)	346,392
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	9,220
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)	745
62 SUPPLIES (SEE INSTRUCTIONS)	11,840
63 TOTAL ALLOWANCE (SUM OF LINES 57-62)	368,197
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	264,291
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)	264,291
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)	264,291
68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL

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

I PROVIDER NO:
I 15-1320
I

IN LIEU OF FORM CMS-2552-96(12/1999)
I PERIOD: I PREPARED 2/27/2008
I FROM 10/ 1/2006 I WORKSHEET A-8-4
I TO 9/30/2007 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)

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	ENTERED
4.01	NEW CAP REL COSTS-MVBLE EQUIP MOB	2	SQUARE	FEET	NOT ENTERED
4.02	NEW CAP REL COSTS-MVBLE EQUIP-POB	3	SQUARE	FEET	NOT ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	NOT ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
8.01	OPERATION OF PLANT-MOB	2	SQUARE	FEET	NOT ENTERED
8.02	OPERATION OF PLANT-POB	3	SQUARE	FEET	NOT ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	FTE'S		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING FTE	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	NOT ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B
 I I TO 9/30/2007 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION 0	NEW CAP REL C OSTS-MVBLE E 4	NEW CAP REL C OSTS-MVBLE E 4.01	NEW CAP REL C OSTS-MVBLE E 4.02	EMPLOYEE BENE FITS 5	SUBTOTAL 5a.00	ADMINISTRATIVE & GENERAL 6
004 GENERAL SERVICE COST CNTR							
004 01 NEW CAP REL COSTS-MVBLE E	1,136,301	1,136,301					
004 02 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS	2,448,430				2,448,430		
006 ADMINISTRATIVE & GENERAL	2,778,696	99,294			398,724	3,276,714	3,276,714
008 OPERATION OF PLANT	893,269	54,036			82,411	1,029,716	209,274
008 01 OPERATION OF PLANT-MOB							
008 02 OPERATION OF PLANT-POB							
009 LAUNDRY & LINEN SERVICE	63,307	6,156			11,514	80,977	16,457
010 HOUSEKEEPING	272,067	4,898			65,850	342,815	69,672
011 DIETARY	333,742	25,961			62,086	421,789	85,722
012 CAFETERIA	77,903	20,809			25,622	124,334	25,269
014 NURSING ADMINISTRATION	766,281	19,497			211,758	997,536	202,734
015 CENTRAL SERVICES & SUPPLY	234,733	27,032			18,475	280,240	56,955
017 MEDICAL RECORDS & LIBRARY	377,634	17,263			84,612	479,509	97,453
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	1,422,482	163,658			393,440	1,979,580	402,321
026 INTENSIVE CARE UNIT							
031 SUBPROVIDER	950,193	62,039			147,062	1,159,294	235,609
033 NURSERY	132,439	13,824			36,772	183,035	37,199
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	1,253,676	159,714			199,628	1,613,018	327,822
039 DELIVERY ROOM & LABOR ROO	18,196	1,700			5,052	24,948	5,070
040 ANESTHESIOLOGY	210,842				68,737	279,579	56,820
041 RADIOLOGY-DIAGNOSTIC	1,343,029	53,662			183,756	1,580,447	321,202
044 LABORATORY	1,221,973	43,157			138,876	1,404,006	285,343
049 RESPIRATORY THERAPY	293,035	3,747				296,782	60,316
050 PHYSICAL THERAPY	433,927					433,927	88,189
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY	83,332	13,382			17,739	114,453	23,261
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS	1,080,555	14,854			93,861	1,189,270	241,701
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	1,102,589	56,204			177,561	1,336,354	271,594
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE	173,361				24,894	198,255	40,292
085 SPEC PURPOSE COST CENTERS							
085 HEART ACQUISITION							
095 SUBTOTALS	19,101,992	860,887			2,448,430	18,826,578	3,160,275
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP		6,691				6,691	1,360
098 PHYSICIANS' PRIVATE OFFIC							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	5,900	158,456				164,356	33,403
100 01 ORTHO	5,175	77,147				82,322	16,731
100 02 WEST JAY CLINIC	286,435	33,120				319,555	64,945
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	19,399,502	1,136,301			2,448,430	19,399,502	3,276,714

COST ALLOCATION - GENERAL SERVICE COSTS

COST CENTER DESCRIPTION	OPERATION OF PLANT 8	OPERATION OF PLANT-MOB 8.01	OPERATION OF PLANT-POB 8.02	LAUNDRY & LINEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12
004 GENERAL SERVICE COST CNTR							
004 01 NEW CAP REL COSTS-MVBLE E							
004 02 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	1,238,990						
008 01 OPERATION OF PLANT-MOB							
008 02 OPERATION OF PLANT-POB							
009 LAUNDRY & LINEN SERVICE	7,759			105,193			
010 HOUSEKEEPING	6,173			2,615	421,275		
011 DIETARY	32,723			1,918	12,930	555,082	
012 CAFETERIA	26,229				10,364		186,196
014 NURSING ADMINISTRATION	24,576				9,711		15,974
015 CENTRAL SERVICES & SUPPLY	34,072				13,463		3,338
017 MEDICAL RECORDS & LIBRARY	21,759				8,598		13,968
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	206,286			63,640	77,112	351,928	44,739
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER	78,197			9,473	30,898	203,154	20,429
037 NURSERY	17,424			2,441	6,885		3,696
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	201,312			18,830	79,542		20,673
040 DELIVERY ROOM & LABOR ROO	2,142				846		501
041 ANESTHESIOLOGY							1,476
044 RADIOLOGY-DIAGNOSTIC	67,638				26,726		18,667
049 LABORATORY	54,397				21,494		17,177
050 RESPIRATORY THERAPY	4,723				1,866		
052 PHYSICAL THERAPY				2,092			
053 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY	16,867				6,665		1,461
056 MEDICAL SUPPLIES CHARGED							
061 DRUGS CHARGED TO PATIENTS	18,723				7,398		6,977
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY	70,843			2,615	27,992		17,120
085 OBSERVATION BEDS (NON-DIS							
095 OTHER OUTPATIENT SERVICE				1,395			
096 SPEC PURPOSE COST CENTERS							
098 HEART ACQUISITION							
099 SUBTOTALS	891,843			105,019	342,490	555,082	186,196
100 NONREIMBURS COST CENTERS							
100 01 GIFT, FLOWER, COFFEE SHOP	8,434				3,332		
100 02 PHYSICIANS' PRIVATE OFFIC							
101 NONPAID WORKERS							
102 OTHER NONREIMBURSABLE COS	199,726				37,030		
103 01 ORTHO	97,240				38,423		
103 02 WEST JAY CLINIC	41,747			174			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,238,990			105,193	421,275	555,082	186,196

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/1/2006 I WORKSHEET B
 I I TO 9/30/2007 I PART I

COST CENTER DESCRIPTION		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
		14	15	17	25	26	27
004	GENERAL SERVICE COST CNTR						
004	01 NEW CAP REL COSTS-MVBLE E						
004	02 NEW CAP REL COSTS-MVBLE E						
005	EMPLOYEE BENEFITS						
006	ADMINISTRATIVE & GENERAL						
008	OPERATION OF PLANT						
008	01 OPERATION OF PLANT-MOB						
008	02 OPERATION OF PLANT-POB						
009	LAUNDRY & LINEN SERVICE						
010	HOUSEKEEPING						
011	DIETARY						
012	CAFETERIA						
014	NURSING ADMINISTRATION	1,250,531					
015	CENTRAL SERVICES & SUPPLY		388,068				
017	MEDICAL RECORDS & LIBRARY			621,287			
025	INPAT ROUTINE SRVC CNTRS						
026	ADULTS & PEDIATRICS	543,398	28,812	56,254	3,754,070		3,754,070
031	INTENSIVE CARE UNIT						
033	SUBPROVIDER	248,123	6,167	31,255	2,022,599		2,022,599
037	NURSERY			2,007	252,687		252,687
037	ANCILLARY SRVC COST CNTRS						
039	OPERATING ROOM	251,081	127,501	98,874	2,738,653		2,738,653
040	DELIVERY ROOM & LABOR ROO			2,787	36,294		36,294
041	ANESTHESIOLOGY			24,080	361,955		361,955
044	RADIOLOGY-DIAGNOSTIC		45,528	178,453	2,238,661		2,238,661
049	LABORATORY		96,686	96,471	1,975,574		1,975,574
050	RESPIRATORY THERAPY		4,637	11,818	380,142		380,142
052	PHYSICAL THERAPY		6,174	18,614	548,996		548,996
053	SPEECH PATHOLOGY						
055	ELECTROCARDIOLOGY		1,613	2,178	166,498		166,498
056	MEDICAL SUPPLIES CHARGED		37,831	631	38,462		38,462
061	DRUGS CHARGED TO PATIENTS		6,298	50,414	1,520,781		1,520,781
062	OUTPAT SERVICE COST CNTRS						
063	EMERGENCY	207,929	22,297	41,965	1,998,709		1,998,709
085	OBSERVATION BEDS (NON-DIS		1,843	5,486	247,271		247,271
095	OTHER OUTPATIENT SERVICE						
096	SPEC PURPOSE COST CENTERS						
098	HEART ACQUISITION						
099	SUBTOTALS	1,250,531	385,387	621,287	18,281,352		18,281,352
100	NONREIMBURS COST CENTERS						
100	GIFT, FLOWER, COFFEE SHOP				19,817		19,817
100	PHYSICIANS' PRIVATE OFFIC						
100	NONPAID WORKERS						
100	01 OTHER NONREIMBURSABLE COS		469		434,984		434,984
100	02 WEST JAY CLINIC		700		235,416		235,416
101	CROSS FOOT ADJUSTMENT		1,512		427,933		427,933
102	NEGATIVE COST CENTER						
103	TOTAL	1,250,531	388,068	621,287	19,399,502		19,399,502

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B
 I I TO 9/30/2007 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OST-S-MVBLE E	NEW CAP REL C OST-S-MVBLE E	NEW CAP REL C OST-S-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL
	0	4	4.01	4.02	4a	5	6
004 GENERAL SERVICE COST CNTR							
004 01 NEW CAP REL COSTS-MVBLE E							
004 02 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		99,294			99,294		99,294
008 OPERATION OF PLANT		54,036			54,036		6,342
008 01 OPERATION OF PLANT-MOB							
008 02 OPERATION OF PLANT-POB							
009 LAUNDRY & LINEN SERVICE		6,156			6,156		499
010 HOUSEKEEPING		4,898			4,898		2,111
011 DIETARY		25,961			25,961		2,598
012 CAFETERIA		20,809			20,809		766
014 NURSING ADMINISTRATION		19,497			19,497		6,144
015 CENTRAL SERVICES & SUPPLY		27,032			27,032		1,726
017 MEDICAL RECORDS & LIBRARY		17,263			17,263		2,953
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS		163,658			163,658		12,185
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER		62,039			62,039		7,140
037 NURSERY		13,824			13,824		1,127
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM		159,714			159,714		9,935
040 DELIVERY ROOM & LABOR ROO		1,700			1,700		154
041 ANESTHESIOLOGY							1,722
044 RADIOLOGY-DIAGNOSTIC		53,662			53,662		9,734
049 LABORATORY		43,157			43,157		8,647
050 RESPIRATORY THERAPY		3,747			3,747		1,828
052 PHYSICAL THERAPY							2,673
053 SPEECH PATHOLOGY							
055 ELECTROCARDIOLOGY		13,382			13,382		705
056 MEDICAL SUPPLIES CHARGED							
061 DRUGS CHARGED TO PATIENTS		14,854			14,854		7,325
062 OUTPAT SERVICE COST CNTRS							
063 EMERGENCY		56,204			56,204		8,231
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							1,221
085 SPEC PURPOSE COST CENTERS							
095 HEART ACQUISITION							
095 SUBTOTALS		860,887			860,887		95,766
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		6,691			6,691		41
099 PHYSICIANS' PRIVATE OFFIC							
100 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS		158,456			158,456		1,012
100 01 ORTHO		77,147			77,147		507
100 02 WEST JAY CLINIC		33,120			33,120		1,968
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		1,136,301			1,136,301		99,294

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B
 I I TO 9/30/2007 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	OPERATION OF PLANT-MOB	OPERATION OF PLANT-POB	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	8	8.01	8.02	9	10	11	12
004 GENERAL SERVICE COST CNTR							
004 01 NEW CAP REL COSTS-MVBLE E							
004 02 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL							
008 OPERATION OF PLANT	60,378						
008 01 OPERATION OF PLANT-MOB							
008 02 OPERATION OF PLANT-POB							
009 LAUNDRY & LINEN SERVICE				7,033			
010 HOUSEKEEPING				175	7,485		
011 DIETARY				128	230	30,512	
012 CAFETERIA					184		23,037
014 NURSING ADMINISTRATION					173		1,976
015 CENTRAL SERVICES & SUPPLY					239		413
017 MEDICAL RECORDS & LIBRARY					153		1,728
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	10,054			4,255	1,370	19,345	5,535
031 INTENSIVE CARE UNIT							
033 SUBPROVIDER	3,811			633	549	11,167	2,528
037 NURSERY	849			163	122		457
039 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	9,810			1,259	1,414		2,558
041 DELIVERY ROOM & LABOR ROO	104				15		62
044 ANESTHESIOLOGY							183
049 RADIOLOGY-DIAGNOSTIC	3,296				475		2,310
050 LABORATORY	2,651				382		2,125
052 RESPIRATORY THERAPY	230				33		
053 PHYSICAL THERAPY				140			
055 SPEECH PATHOLOGY							
056 ELECTROCARDIOLOGY	822				118		181
061 MEDICAL SUPPLIES CHARGED							
062 DRUGS CHARGED TO PATIENTS	912				131		863
063 OUTPAT SERVICE COST CNTRS							
066 EMERGENCY	3,452			175	497		2,118
068 OBSERVATION BEDS (NON-DIS							
069 OTHER OUTPATIENT SERVICE				93			
071 SPEC PURPOSE COST CENTERS							
085 HEART ACQUISITION							
095 SUBTOTALS	43,461			7,021	6,085	30,512	23,037
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP	411				59		
099 PHYSICIANS' PRIVATE OFFIC							
100 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE COS	9,733				658		
100 01 ORTHO	4,739				683		
100 02 WEST JAY CLINIC	2,034			12			
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	60,378			7,033	7,485	30,512	23,037

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B
 I I TO 9/30/2007 I PART III

COST CENTER DESCRIPTION	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPLY 15	MEDICAL RECORDS & LIBRARY 17	SUBTOTAL 25	POST STEPDOWN ADJUSTMENT 26	TOTAL 27
004 GENERAL SERVICE COST CNTR						
004 01 NEW CAP REL COSTS-MVBLE E						
004 02 NEW CAP REL COSTS-MVBLE E						
005 EMPLOYEE BENEFITS						
006 ADMINISTRATIVE & GENERAL						
008 OPERATION OF PLANT						
008 01 OPERATION OF PLANT-MOB						
008 02 OPERATION OF PLANT-POB						
009 LAUNDRY & LINEN SERVICE						
010 HOUSEKEEPING						
011 DIETARY						
012 CAFETERIA						
014 NURSING ADMINISTRATION	28,988					
015 CENTRAL SERVICES & SUPPLY		31,070				
017 MEDICAL RECORDS & LIBRARY			23,157			
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	12,596	2,307	2,095	233,400		233,400
031 INTENSIVE CARE UNIT						
031 SUBPROVIDER	5,752	494	1,164	95,277		95,277
033 NURSERY			75	16,617		16,617
037 ANCILLARY SRVC COST CNTRS						
037 OPERATING ROOM	5,820	10,208	3,683	204,401		204,401
039 DELIVERY ROOM & LABOR ROO			104	2,139		2,139
040 ANESTHESIOLOGY			897	2,802		2,802
041 RADIOLOGY-DIAGNOSTIC		3,645	6,662	79,784		79,784
044 LABORATORY		7,741	3,594	68,297		68,297
049 RESPIRATORY THERAPY		371	440	6,649		6,649
050 PHYSICAL THERAPY		494	693	4,000		4,000
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY		129	81	15,418		15,418
055 MEDICAL SUPPLIES CHARGED		3,029	24	3,053		3,053
056 DRUGS CHARGED TO PATIENTS		504	1,878	26,467		26,467
061 OUTPAT SERVICE COST CNTRS						
061 EMERGENCY	4,820	1,785	1,563	78,845		78,845
062 OBSERVATION BEDS (NON-DIS						
062 OTHER OUTPATIENT SERVICE		148	204	1,666		1,666
063 SPEC PURPOSE COST CENTERS						
085 HEART ACQUISITION						
095 SUBTOTALS	28,988	30,855	23,157	838,815		838,815
096 NONREIMBURS COST CENTERS						
096 GIFT, FLOWER, COFFEE SHOP				7,202		7,202
098 PHYSICIANS' PRIVATE OFFIC						
099 NONPAID WORKERS						
100 OTHER NONREIMBURSABLE COS		38		169,897		169,897
100 01 ORTHO		56		83,132		83,132
100 02 WEST JAY CLINIC		121		37,255		37,255
101 CROSS FOOT ADJUSTMENTS						
102 NEGATIVE COST CENTER						
103 TOTAL	28,988	31,070	23,157	1,136,301		1,136,301

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B-1
 I I TO 9/30/2007 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL
	OSTS-MVBLE E	OSTS-MVBLE E	OSTS-MVBLE E	FITS		(ACCUM. COST)
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(GROSS SALARIES)		
	4	4.01	4.02	5	6a.00	6
GENERAL SERVICE COST						
004 NEW CAP REL COSTS-MVB	84,913					
004 01 NEW CAP REL COSTS-MVB						
004 02 NEW CAP REL COSTS-MVB						
005 EMPLOYEE BENEFITS				8,076,322		
006 ADMINISTRATIVE & GENE	7,420			1,315,229	-3,276,714	16,122,788
008 OPERATION OF PLANT	4,038			271,839		1,029,716
008 01 OPERATION OF PLANT-MO						
008 02 OPERATION OF PLANT-PO						
009 LAUNDRY & LINEN SERVI	460			37,981		80,977
010 HOUSEKEEPING	366			217,209		342,815
011 DIETARY	1,940			204,794		421,789
012 CAFETERIA	1,555			84,515		124,334
014 NURSING ADMINISTRATIO	1,457			698,497		997,536
015 CENTRAL SERVICES & SU	2,020			60,941		280,240
017 MEDICAL RECORDS & LIB	1,290			279,098		479,509
INPAT ROUTINE SRVC CN						
025 ADULTS & PEDIATRICS	12,230			1,297,788		1,979,580
026 INTENSIVE CARE UNIT						
031 SUBPROVIDER	4,636			485,095		1,159,294
033 NURSERY	1,033			121,295		183,035
ANCILLARY SRVC COST C						
037 OPERATING ROOM	11,935			658,486		1,613,018
039 DELIVERY ROOM & LABOR	127			16,665		24,948
040 ANESTHESIOLOGY				226,734		279,579
041 RADIOLOGY-DIAGNOSTIC	4,010			606,132		1,580,447
044 LABORATORY	3,225			458,092		1,404,006
049 RESPIRATORY THERAPY	280					296,782
050 PHYSICAL THERAPY						433,927
052 SPEECH PATHOLOGY						
053 ELECTROCARDIOLOGY	1,000			58,512		114,453
055 MEDICAL SUPPLIES CHAR						
056 DRUGS CHARGED TO PATI	1,110			309,608		1,189,270
OUTPAT SERVICE COST C						
061 EMERGENCY	4,200			585,697		1,336,354
062 OBSERVATION BEDS (NON						
063 OTHER OUTPATIENT SERV				82,115		198,255
SPEC PURPOSE COST CEN						
085 HEART ACQUISITION						
095 SUBTOTALS	64,332			8,076,322	-3,276,714	15,549,864
NONREIMBURS COST CENT						
096 GIFT, FLOWER, COFFEE	500					6,691
098 PHYSICIANS' PRIVATE O						
099 NONPAID WORKERS						
100 OTHER NONREIMBURSABLE	11,841					164,356
100 01 ORTHO	5,765					82,322
100 02 WEST JAY CLINIC	2,475					319,555
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,136,301			2,448,430		3,276,714
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	13.381944			.303162		.203235
(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						99,294
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER						.006159
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET B-1
 I I TO 9/30/2007 I

COST CENTER DESCRIPTION	OPERATION OF PLANT	OPERATION OF PLANT-MOB	OPERATION OF PLANT-POB	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)
	8	8.01	8.02	9	10	11	12
GENERAL SERVICE COST							
004 NEW CAP REL COSTS-MVB							
004 01 NEW CAP REL COSTS-MVB							
004 02 NEW CAP REL COSTS-MVB							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENE							
008 OPERATION OF PLANT	73,455						
008 01 OPERATION OF PLANT-MO							
008 02 OPERATION OF PLANT-PO							
009 LAUNDRY & LINEN SERVI	460			36,200			
010 HOUSEKEEPING	366			900	63,209		
011 DIETARY	1,940			660	1,940	22,099	
012 CAFETERIA	1,555				1,555		12,997
014 NURSING ADMINISTRATIO	1,457				1,457		1,115
015 CENTRAL SERVICES & SU	2,020				2,020		233
017 MEDICAL RECORDS & LIB	1,290				1,290		975
025 INPAT ROUTINE SRVC CN							
026 ADULTS & PEDIATRICS	12,230			21,900	11,570	14,011	3,123
031 INTENSIVE CARE UNIT							
031 SUBPROVIDER	4,636			3,260	4,636	8,088	1,426
033 NURSERY	1,033			840	1,033		258
ANCILLARY SRVC COST C							
037 OPERATING ROOM	11,935			6,480	11,935		1,443
039 DELIVERY ROOM & LABOR	127				127		35
040 ANESTHESIOLOGY							103
041 RADIOLOGY-DIAGNOSTIC	4,010				4,010		1,303
044 LABORATORY	3,225				3,225		1,199
049 RESPIRATORY THERAPY	280				280		
050 PHYSICAL THERAPY				720			
052 SPEECH PATHOLOGY							
053 ELECTROCARDIOLOGY	1,000				1,000		102
055 MEDICAL SUPPLIES CHAR							
056 DRUGS CHARGED TO PATI	1,110				1,110		487
OUTPAT SERVICE COST C							
061 EMERGENCY	4,200			900	4,200		1,195
062 OBSERVATION BEDS (NON							
063 OTHER OUTPATIENT SERV				480			
SPEC PURPOSE COST CEN							
085 HEART ACQUISITION							
095 SUBTOTALS	52,874			36,140	51,388	22,099	12,997
NONREIMBURS COST CENT							
096 GIFT, FLOWER, COFFEE	500				500		
098 PHYSICIANS' PRIVATE O							
099 NONPAID WORKERS							
100 OTHER NONREIMBURSABLE	11,841				5,556		
100 01 ORTHO	5,765				5,765		
100 02 WEST JAY CLINIC	2,475			60			
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	1,238,990			105,193	421,275	555,082	186,196
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	16.867334			2.905884	6.664795	25.117969	14.326075
(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	60,378			7,033	7,485	30,512	23,037
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER	.821973			.194282	.118417	1.380696	1.772486
(WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NURSING ADMIN	CENTRAL SERVI	MEDICAL RECOR
	ISTRATION	CES & SUPPLY	DS & LIBRARY
	(DIRECT NRSNG FTE)	(COSTED REQUIS.)	(GROSS CHARGES)
	14	15	17
GENERAL SERVICE COST			
004 NEW CAP REL COSTS-MVB			
004 01 NEW CAP REL COSTS-MVB			
004 02 NEW CAP REL COSTS-MVB			
005 EMPLOYEE BENEFITS			
006 ADMINISTRATIVE & GENE			
008 OPERATION OF PLANT			
008 01 OPERATION OF PLANT-MO			
008 02 OPERATION OF PLANT-PO			
009 LAUNDRY & LINEN SERVI			
010 HOUSEKEEPING			
011 DIETARY			
012 CAFETERIA			
014 NURSING ADMINISTRATIO	7,187		
015 CENTRAL SERVICES & SU		1,647,280	
017 MEDICAL RECORDS & LIB			44,082,908
INPAT ROUTINE SRVC CN			
025 ADULTS & PEDIATRICS	3,123	122,300	3,991,315
026 INTENSIVE CARE UNIT			
031 SUBPROVIDER	1,426	26,177	2,217,600
033 NURSERY			142,400
ANCILLARY SRVC COST C			
037 OPERATING ROOM	1,443	541,226	7,015,358
039 DELIVERY ROOM & LABOR			197,714
040 ANESTHESIOLOGY			1,708,521
041 RADIOLOGY-DIAGNOSTIC		193,258	12,662,976
044 LABORATORY		410,415	6,844,794
049 RESPIRATORY THERAPY		19,683	838,538
050 PHYSICAL THERAPY		26,207	1,320,688
052 SPEECH PATHOLOGY			
053 ELECTROCARDIOLOGY		6,847	154,512
055 MEDICAL SUPPLIES CHAR		160,585	44,764
056 DRUGS CHARGED TO PATI		26,733	3,577,000
OUTPAT SERVICE COST C			
061 EMERGENCY	1,195	94,645	2,977,492
062 OBSERVATION BEDS (NON			
063 OTHER OUTPATIENT SERV		7,823	389,236
SPEC PURPOSE COST CEN			
085 HEART ACQUISITION			
095 SUBTOTALS	7,187	1,635,899	44,082,908
NONREIMBURS COST CENT			
096 GIFT, FLOWER, COFFEE			
098 PHYSICIANS' PRIVATE O			
099 NONPAID WORKERS			
100 OTHER NONREIMBURSABLE		1,992	
100 01 ORTHO		2,970	
100 02 WEST JAY CLINIC		6,419	
101 CROSS FOOT ADJUSTMENT			
102 NEGATIVE COST CENTER			
103 COST TO BE ALLOCATED	1,250,531	388,068	621,287
(PER WRKSHT B, PART			
104 UNIT COST MULTIPLIER		.235581	
(WRKSHT B, PT I)	173.999026		.014094
105 COST TO BE ALLOCATED			
(PER WRKSHT B, PART			
106 UNIT COST MULTIPLIER			
(WRKSHT B, PT II)			
107 COST TO BE ALLOCATED	28,988	31,070	23,157
(PER WRKSHT B, PART			
108 UNIT COST MULTIPLIER		.018861	
(WRKSHT B, PT III)	4.033394		.000525

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
 I I TO 9/30/2007 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	3,754,070		3,754,070		3,754,070
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER	2,022,599		2,022,599		2,022,599
33	NURSERY	252,687		252,687		252,687
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	2,738,653		2,738,653		2,738,653
39	DELIVERY ROOM & LABOR ROO	36,294		36,294		36,294
40	ANESTHESIOLOGY	361,955		361,955		361,955
41	RADIOLOGY-DIAGNOSTIC	2,238,661		2,238,661		2,238,661
44	LABORATORY	1,975,574		1,975,574		1,975,574
49	RESPIRATORY THERAPY	380,142		380,142		380,142
50	PHYSICAL THERAPY	548,996		548,996		548,996
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	166,498		166,498		166,498
55	MEDICAL SUPPLIES CHARGED	38,462		38,462		38,462
56	DRUGS CHARGED TO PATIENTS	1,520,781		1,520,781		1,520,781
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,998,709		1,998,709		1,998,709
62	OBSERVATION BEDS (NON-DIS	442,356		442,356		442,356
63	OTHER OUTPATIENT SERVICE	247,271		247,271		247,271
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	18,723,708		18,723,708		18,723,708
102	LESS OBSERVATION BEDS	442,356		442,356		442,356
103	TOTAL	18,281,352		18,281,352		18,281,352

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
 I I TO 9/30/2007 I PART I

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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	3,310,165		3,310,165			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER	2,217,600		2,217,600			
33	NURSERY	142,400		142,400			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,614,980	5,400,378	7,015,358	.390380	.390380	.390380
39	DELIVERY ROOM & LABOR ROO	197,714		197,714	.183568	.183568	.183568
40	ANESTHESIOLOGY	455,350	1,253,171	1,708,521	.211853	.211853	.211853
41	RADIOLOGY-DIAGNOSTIC	844,317	11,818,659	12,662,976	.176788	.176788	.176788
44	LABORATORY	1,451,745	5,393,049	6,844,794	.288624	.288624	.288624
49	RESPIRATORY THERAPY	714,321	124,217	838,538	.453339	.453339	.453339
50	PHYSICAL THERAPY	555,670	765,018	1,320,688	.415689	.415689	.415689
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY		154,512	154,512	1.077573	1.077573	1.077573
55	MEDICAL SUPPLIES CHARGED	13,631	31,133	44,764	.859217	.859217	.859217
56	DRUGS CHARGED TO PATIENTS	1,458,819	2,118,181	3,577,000	.425155	.425155	.425155
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	70,954	2,906,538	2,977,492	.671273	.671273	.671273
62	OBSERVATION BEDS (NON-DIS	71,110	610,040	681,150	.649425	.649425	.649425
63	OTHER OUTPATIENT SERVICE	82,442	306,794	389,236	.635273	.635273	.635273
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	13,201,218	30,881,690	44,082,908			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,201,218	30,881,690	44,082,908			

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
I I TO 9/30/2007 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	3,754,070		3,754,070		3,754,070
26	INTENSIVE CARE UNIT					
31	SUBPROVIDER	2,022,599		2,022,599		2,022,599
33	NURSERY	252,687		252,687		252,687
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	2,738,653		2,738,653		2,738,653
39	DELIVERY ROOM & LABOR ROO	36,294		36,294		36,294
40	ANESTHESIOLOGY	361,955		361,955		361,955
41	RADIOLOGY-DIAGNOSTIC	2,238,661		2,238,661		2,238,661
44	LABORATORY	1,975,574		1,975,574		1,975,574
49	RESPIRATORY THERAPY	380,142		380,142		380,142
50	PHYSICAL THERAPY	548,996		548,996		548,996
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY	166,498		166,498		166,498
55	MEDICAL SUPPLIES CHARGED	38,462		38,462		38,462
56	DRUGS CHARGED TO PATIENTS	1,520,781		1,520,781		1,520,781
61	OUTPAT SERVICE COST CNTRS EMERGENCY	1,998,709		1,998,709		1,998,709
62	OBSERVATION BEDS (NON-DIS	442,356		442,356		442,356
63	OTHER OUTPATIENT SERVICE	247,271		247,271		247,271
101	OTHER REIMBURS COST CNTRS SUBTOTAL	18,723,708		18,723,708		18,723,708
102	LESS OBSERVATION BEDS	442,356		442,356		442,356
103	TOTAL	18,281,352		18,281,352		18,281,352

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
I I TO 9/30/2007 I PART I

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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	3,310,165		3,310,165			
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER	2,217,600		2,217,600			
33	NURSERY	142,400		142,400			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	1,614,980	5,400,378	7,015,358	.390380	.390380	.390380
39	DELIVERY ROOM & LABOR ROO	197,714		197,714	.183568	.183568	.183568
40	ANESTHESIOLOGY	455,350	1,253,171	1,708,521	.211853	.211853	.211853
41	RADIOLOGY-DIAGNOSTIC	844,317	11,818,659	12,662,976	.176788	.176788	.176788
44	LABORATORY	1,451,745	5,393,049	6,844,794	.288624	.288624	.288624
49	RESPIRATORY THERAPY	714,321	124,217	838,538	.453339	.453339	.453339
50	PHYSICAL THERAPY	555,670	765,018	1,320,688	.415689	.415689	.415689
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY		154,512	154,512	1.077573	1.077573	1.077573
55	MEDICAL SUPPLIES CHARGED	13,631	31,133	44,764	.859217	.859217	.859217
56	DRUGS CHARGED TO PATIENTS	1,458,819	2,118,181	3,577,000	.425155	.425155	.425155
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	70,954	2,906,538	2,977,492	.671273	.671273	.671273
62	OBSERVATION BEDS (NON-DIS	71,110	610,040	681,150	.649425	.649425	.649425
63	OTHER OUTPATIENT SERVICE	82,442	306,794	389,236	.635273	.635273	.635273
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	13,201,218	30,881,690	44,082,908			
102	LESS OBSERVATION BEDS						
103	TOTAL	13,201,218	30,881,690	44,082,908			

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
 I I TO 9/30/2007 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						
	OPERATING ROOM	2,738,653	204,401	2,534,252			2,738,653
39	DELIVERY ROOM & LABOR ROO	36,294	2,139	34,155			36,294
40	ANESTHESIOLOGY	361,955	2,802	359,153			361,955
41	RADIOLOGY-DIAGNOSTIC	2,238,661	79,784	2,158,877			2,238,661
44	LABORATORY	1,975,574	68,297	1,907,277			1,975,574
49	RESPIRATORY THERAPY	380,142	6,649	373,493			380,142
50	PHYSICAL THERAPY	548,996	4,000	544,996			548,996
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	166,498	15,418	151,080			166,498
55	MEDICAL SUPPLIES CHARGED	38,462	3,053	35,409			38,462
56	DRUGS CHARGED TO PATIENTS	1,520,781	26,467	1,494,314			1,520,781
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,998,709	78,845	1,919,864			1,998,709
62	OBSERVATION BEDS (NON-DIS	442,356		442,356			442,356
63	OTHER OUTPATIENT SERVICE	247,271	1,666	245,605			247,271
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	12,694,352	493,521	12,200,831			12,694,352
102	LESS OBSERVATION BEDS	442,356		442,356			442,356
103	TOTAL	12,251,996	493,521	11,758,475			12,251,996

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL
 CALCULATION OF OUTPATIENT SERVICE COST TO
 CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
 I I TO 9/30/2007 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	7,015,358	.390380	.390380
39	DELIVERY ROOM & LABOR ROO	197,714	.183568	.183568
40	ANESTHESIOLOGY	1,708,521	.211853	.211853
41	RADIOLOGY-DIAGNOSTIC	12,662,976	.176788	.176788
44	LABORATORY	6,844,794	.288624	.288624
49	RESPIRATORY THERAPY	838,538	.453339	.453339
50	PHYSICAL THERAPY	1,320,688	.415689	.415689
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	154,512	1.077573	1.077573
55	MEDICAL SUPPLIES CHARGED	44,764	.859217	.859217
56	DRUGS CHARGED TO PATIENTS	3,577,000	.425155	.425155
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	2,977,492	.671273	.671273
62	OBSERVATION BEDS (NON-DIS	681,150	.649425	.649425
63	OTHER OUTPATIENT SERVICE	389,236	.635273	.635273
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	38,412,743		
102	LESS OBSERVATION BEDS	681,150		
103	TOTAL	37,731,593		

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

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET C
 I I TO 9/30/2007 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	2,738,653	204,401	2,534,252			2,738,653
39	OPERATING ROOM	36,294	2,139	34,155			36,294
40	DELIVERY ROOM & LABOR ROO	361,955	2,802	359,153			361,955
41	ANESTHESIOLOGY	2,238,661	79,784	2,158,877			2,238,661
44	RADIOLOGY-DIAGNOSTIC	1,975,574	68,297	1,907,277			1,975,574
49	LABORATORY	380,142	6,649	373,493			380,142
50	RESPIRATORY THERAPY	548,996	4,000	544,996			548,996
52	PHYSICAL THERAPY						
53	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY	166,498	15,418	151,080			166,498
55	MEDICAL SUPPLIES CHARGED	38,462	3,053	35,409			38,462
56	DRUGS CHARGED TO PATIENTS	1,520,781	26,467	1,494,314			1,520,781
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	1,998,709	78,845	1,919,864			1,998,709
62	OBSERVATION BEDS (NON-DIS	442,356		442,356			442,356
63	OTHER OUTPATIENT SERVICE	247,271	1,666	245,605			247,271
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	12,694,352	493,521	12,200,831			12,694,352
102	LESS OBSERVATION BEDS	442,356		442,356			442,356
103	TOTAL	12,251,996	493,521	11,758,475			12,251,996

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

I PROVIDER NO: I PERIOD: I (09/2000)
 I 15-1320 I FROM 10/ 1/2006 I PREPARED 2/27/2008
 I I TO 9/30/2007 I WORKSHEET C
 I PART II

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	7,015,358	.390380	.390380
39	DELIVERY ROOM & LABOR ROO	197,714	.183568	.183568
40	ANESTHESIOLOGY	1,708,521	.211853	.211853
41	RADIOLOGY-DIAGNOSTIC	12,662,976	.176788	.176788
44	LABORATORY	6,844,794	.288624	.288624
49	RESPIRATORY THERAPY	838,538	.453339	.453339
50	PHYSICAL THERAPY	1,320,688	.415689	.415689
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	154,512	1.077573	1.077573
55	MEDICAL SUPPLIES CHARGED	44,764	.859217	.859217
56	DRUGS CHARGED TO PATIENTS	3,577,000	.425155	.425155
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	2,977,492	.671273	.671273
62	OBSERVATION BEDS (NON-DIS	681,150	.649425	.649425
63	OTHER OUTPATIENT SERVICE	389,236	.635273	.635273
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	38,412,743		
102	LESS OBSERVATION BEDS	681,150		
103	TOTAL	37,731,593		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I I TO 9/30/2007 I PART I

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL		
		CAPITAL REL COST (B, II) 1	SWING BED ADJUSTMENT 2	REDUCED CAP RELATED COST 3	CAPITAL REL COST (B, III) 4	SWING BED ADJUSTMENT 5	REDUCED CAP RELATED COST 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS				233,400	72,775	160,625
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER				95,277		95,277
33	NURSERY				16,617		16,617
101	TOTAL				345,294		272,519

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I I TO 9/30/2007 I PART I

TITLE XVIII, PART A

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 7	INPATIENT PROGRAM DAYS 8	OLD CAPITAL PER DIEM 9	INPAT PROGRAM OLD CAP CST 10	NEW CAPITAL PER DIEM 11	INPAT PROGRAM NEW CAP CST 12
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	3,294	1,530			48.76	74,603
26	INTENSIVE CARE UNIT						
31	SUBPROVIDER	2,467	2,279			38.62	88,015
33	NURSERY	178				93.35	
101	TOTAL	5,939	3,809				162,618

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I I TO 9/30/2007 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	MED EDUCATN COST 2	SWING BED ADJ AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					3,294	
26	INTENSIVE CARE UNIT					2,467	
31	SUBPROVIDER					178	
33	NURSERY					178	
101	TOTAL					5,939	

APPORTIONMENT OF INPATIENT ROUTINE
 SERVICE OTHER PASS THROUGH COSTS
 TITLE XVIII, PART A

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I I TO 9/30/2007 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
		7	8
25	ADULTS & PEDIATRICS		1,530
26	INTENSIVE CARE UNIT		
31	SUBPROVIDER		2,279
33	NURSERY		
101	TOTAL		3,809

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART V
 I 15-1320 I I

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	.390380		.390380		
39 DELIVERY ROOM & LABOR ROOM	.183568		.183568		
40 ANESTHESIOLOGY	.211853		.211853		
41 RADIOLOGY-DIAGNOSTIC	.176788		.176788		
44 LABORATORY	.288624		.288624		
49 RESPIRATORY THERAPY	.453339		.453339		
50 PHYSICAL THERAPY	.415689		.415689		
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY	1.077573		1.077573		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217		.859217		
56 DRUGS CHARGED TO PATIENTS	.425155		.425155		
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.671273		.671273		
62 OBSERVATION BEDS (NON-DISTINCT PART)	.649425		.649425		
63 OTHER OUTPATIENT SERVICE COST CENTER	.635273		.635273		
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)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART V
 I 15-1320 I I

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		1,376,322			
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		3,237,038			
44 LABORATORY		2,077,418			
49 RESPIRATORY THERAPY		35,745			
50 PHYSICAL THERAPY		249,951			
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY		107,514			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		5,094			
56 DRUGS CHARGED TO PATIENTS		1,145,370			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		945,558			
62 OBSERVATION BEDS (NON-DISTINCT PART)		245,205			
63 OTHER OUTPATIENT SERVICE COST CENTER		68,879			
101 SUBTOTAL		9,494,094			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		9,494,094			

(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 COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART V
 I 15-1320 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	All Other		Hospital I/P	Hospital I/P
	9		Part B Charges	Part B Costs
(A) ANCILLARY SRVC COST CNTRS				
37 OPERATING ROOM	537,289			
39 DELIVERY ROOM & LABOR ROOM				
40 ANESTHESIOLOGY				
41 RADIOLOGY-DIAGNOSTIC	572,269			
44 LABORATORY	599,593			
49 RESPIRATORY THERAPY	16,205			
50 PHYSICAL THERAPY	103,902			
52 SPEECH PATHOLOGY				
53 ELECTROCARDIOLOGY	115,854			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,377			
56 DRUGS CHARGED TO PATIENTS	486,960			
OUTPAT SERVICE COST CNTRS				
61 EMERGENCY	634,728			
62 OBSERVATION BEDS (NON-DISTINCT PART)	159,242			
63 OTHER OUTPATIENT SERVICE COST CENTER	43,757			
101 SUBTOTAL	3,274,176			
102 CRNA CHARGES				
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES				
104 NET CHARGES	3,274,176			

(A) WORKSHEET A LINE NUMBERS

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

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

IN LIEU OF FORM CMS-2552-96(08/2000) CONTD
I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
I COMPONENT NO: I TO 9/30/2007 I PART VI
I 15-1320 I I

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.425155
2	PROGRAM VACCINE CHARGES		1,854
3	PROGRAM COSTS		788

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART II
 I 15-M320 I

TITLE XVIII, PART A

SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM		204,401	7,015,358			
39	DELIVERY ROOM & LABOR ROO		2,139	197,714			
40	ANESTHESIOLOGY		2,802	1,708,521			
41	RADIOLOGY-DIAGNOSTIC		79,784	12,662,976	59,987		
44	LABORATORY		68,297	6,844,794	234,770		
49	RESPIRATORY THERAPY		6,649	838,538	116,974		
50	PHYSICAL THERAPY		4,000	1,320,688	52,821		
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY		15,418	154,512			
55	MEDICAL SUPPLIES CHARGED		3,053	44,764	147		
56	DRUGS CHARGED TO PATIENTS		26,467	3,577,000	367,390		
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY		78,845	2,977,492	6,355		
62	OBSERVATION BEDS (NON-DIS			681,150			
63	OTHER OUTPATIENT SERVICE		1,666	389,236			
	OTHER REIMBURS COST CNTRS						
101	TOTAL		493,521	38,412,743	838,444		

TITLE XVIII, PART A SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	CST/CHRG 7	NEW CAPITAL RATIO	COSTS 8
37	ANCILLARY SRVC COST CNTRS		.029136	
39	OPERATING ROOM		.010819	
40	DELIVERY ROOM & LABOR ROO		.001640	
41	ANESTHESIOLOGY		.006301	
44	RADIOLOGY-DIAGNOSTIC		.009978	378
49	LABORATORY		.007929	2,343
50	RESPIRATORY THERAPY		.003029	927
52	PHYSICAL THERAPY			160
53	SPEECH PATHOLOGY		.099785	
55	ELECTROCARDIOLOGY		.068202	10
56	MEDICAL SUPPLIES CHARGED		.007399	2,718
61	DRUGS CHARGED TO PATIENTS			
62	OUTPAT SERVICE COST CNTRS		.026480	168
63	EMERGENCY		.004280	
101	OBSERVATION BEDS (NON-DIS OTHER OUTPATIENT SERVICE OTHER REIMBURS COST CNTRS TOTAL			6,704

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL
 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

IN LIEU OF FORM CMS-2552-96(04/2005)
 I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART IV
 I 15-M320 I I

TITLE XVIII, PART A SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

HEALTH FINANCIAL SYSTEMS MCRS/PC-WIN FOR JAY COUNTY HOSPITAL
 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

IN LIEU OF FORM CMS-2552-96(04/2005) CONTD
 I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART IV
 I 15-M320 I

TITLE XVIII, PART A

SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM			7,015,358				
39	DELIVERY ROOM & LABOR ROO			197,714				
40	ANESTHESIOLOGY			1,708,521				
41	RADIOLOGY-DIAGNOSTIC			12,662,976			59,987	
44	LABORATORY			6,844,794			234,770	
49	RESPIRATORY THERAPY			838,538			116,974	
50	PHYSICAL THERAPY			1,320,688			52,821	
52	SPEECH PATHOLOGY							
53	ELECTROCARDIOLOGY			154,512				
55	MEDICAL SUPPLIES CHARGED			44,764			147	
56	DRUGS CHARGED TO PATIENTS			3,577,000			367,390	
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY			2,977,492			6,355	
62	OBSERVATION BEDS (NON-DIS			681,150				
63	OTHER OUTPATIENT SERVICE			389,236				
101	TOTAL			38,412,743			838,444	

TITLE XVIII, PART A

SUBPROVIDER 1

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
		8	8.01	8.02	9	9.01	9.02
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART V
 I 15-1320 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.390380				568,873
39 DELIVERY ROOM & LABOR ROOM	.183568				
40 ANESTHESIOLOGY	.211853				127,696
41 RADIOLOGY-DIAGNOSTIC	.176788				1,261,508
44 LABORATORY	.288624				519,779
49 RESPIRATORY THERAPY	.453339				13,839
50 PHYSICAL THERAPY	.415689				73,130
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY	1.077573				
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217				3,870
56 DRUGS CHARGED TO PATIENTS	.425155				296,943
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	.671273				511,860
62 OBSERVATION BEDS (NON-DISTINCT PART)	.649425				
63 OTHER OUTPATIENT SERVICE COST CENTER	.635273				
101 SUBTOTAL					3,377,498
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					3,377,498

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P	HOSPITAL				
	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 OTHER OUTPATIENT SERVICE COST CENTER					
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)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D
 I COMPONENT NO: I TO 9/30/2007 I PART V
 I 15-1320 I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		222,077			
39 DELIVERY ROOM & LABOR ROOM					
40 ANESTHESIOLOGY		27,053			
41 RADIOLOGY-DIAGNOSTIC		223,019			
44 LABORATORY		150,021			
49 RESPIRATORY THERAPY		6,274			
50 PHYSICAL THERAPY		30,399			
52 SPEECH PATHOLOGY					
53 ELECTROCARDIOLOGY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		3,325			
56 DRUGS CHARGED TO PATIENTS		126,247			
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY		343,598			
63 OBSERVATION BEDS (NON-DISTINCT PART)					
101 OTHER OUTPATIENT SERVICE COST CENTER					
102 SUBTOTAL		1,132,013			
103 CRNA CHARGES					
104 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
NET CHARGES		1,132,013			

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,838
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,294
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,294
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,482
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	62
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,530
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,375
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,754,070
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	8,184
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,170,531
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,583,539

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,864,749
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,864,749
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.668488
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,173.27
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	2,583,539

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM				784.31
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST				1,199,994
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM				
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST				1,199,994

	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				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				
49	TOTAL PROGRAM INPATIENT COSTS				
					802,132
					2,002,126

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)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	1,078,426
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	1,078,426
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	564
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	784.32
85	OBSERVATION BED COST	442,356

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XVIII PART A SUBPROVIDER I PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	2,467
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,467
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) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	2,467
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)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,279
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,022,599
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,022,599

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,217,600
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,217,600
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.912067
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	898.91
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	2,022,599

TITLE XVIII PART A SUBPROVIDER I PPS

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 819.86
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,868,461
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,868,461

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 313,941
49 TOTAL PROGRAM INPATIENT COSTS					2,182,402

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES 88,015
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES 6,704
 52 TOTAL PROGRAM EXCLUDABLE COST 94,719
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS 2,087,683

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

TITLE XVIII PART A SUBPROVIDER I PPS

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	819.86
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	2,022,599			
87	NEW CAPITAL-RELATED COST	2,022,599			
88	NON PHYSICIAN ANESTHETIST	2,022,599	.047106		
89	MEDICAL EDUCATION	2,022,599			
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)	4,838
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,294
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,294
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,482
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	62
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	295
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	178
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	132.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,754,070
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	8,184
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,170,531
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,583,539

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,864,749
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,864,749
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.668488
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,173.27
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	2,583,539

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 784,31
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 231,371
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 231,371

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
42 NURSERY (TITLE V & XIX ONLY)	252,687	178	1,419.59	4	5
43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
44 INTENSIVE CARE UNIT					
45 CORONARY CARE UNIT					
46 BURN INTENSIVE CARE UNIT					
47 SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					245,462 476,833

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

TITLE XIX - I/P HOSPITAL OTHER

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

1

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
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	564
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	784.32
85	OBSERVATION BED COST	442,356

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				

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D-4
 I COMPONENT NO: I TO 9/30/2007 I
 I 15-1320 I

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS		1,361,436	
31	INTENSIVE CARE UNIT SUBPROVIDER			
37	ANCILLARY SRVC COST CNTRS			
39	OPERATING ROOM	.390380	401,350	156,679
40	DELIVERY ROOM & LABOR ROOM	.183568		
41	ANESTHESIOLOGY	.211853		
44	RADIOLOGY-DIAGNOSTIC	.176788	313,668	55,453
49	LABORATORY	.288624	594,516	171,592
50	RESPIRATORY THERAPY	.453339	283,548	128,543
52	PHYSICAL THERAPY	.415689	108,665	45,171
53	SPEECH PATHOLOGY			
55	ELECTROCARDIOLOGY	1.077573		
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217	469	403
61	DRUGS CHARGED TO PATIENTS	.425155	484,936	206,173
62	OUTPAT SERVICE COST CNTRS			
63	EMERGENCY	.671273	1,695	1,138
101	OBSERVATION BEDS (NON-DISTINCT PART)	.649425		
102	OTHER OUTPATIENT SERVICE COST CENTER	.635273	58,211	36,980
103	OTHER REIMBURS COST CNTRS			
	TOTAL		2,247,058	802,132
	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
	NET CHARGES		2,247,058	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D-4
 I COMPONENT NO: I TO 9/30/2007 I
 I 15-M320 I

TITLE XVIII, PART A SUBPROVIDER 1

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS			
26	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER		2,051,100	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.390380		
39	DELIVERY ROOM & LABOR ROOM	.183568		
40	ANESTHESIOLOGY	.211853		
41	RADIOLOGY-DIAGNOSTIC	.176788	59,987	10,605
44	LABORATORY	.288624	234,770	67,760
49	RESPIRATORY THERAPY	.453339	116,974	53,029
50	PHYSICAL THERAPY	.415689	52,821	21,957
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	1.077573		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217	147	126
56	DRUGS CHARGED TO PATIENTS	.425155	367,390	156,198
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.671273	6,355	4,266
62	OBSERVATION BEDS (NON-DISTINCT PART)	.649425		
63	OTHER OUTPATIENT SERVICE COST CENTER	.635273		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		838,444	313,941
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		838,444	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D-4
 I COMPONENT NO: I TO 9/30/2007 I
 I 15-Z320 I

TITLE XVIII, PART A SWING BED SNF

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.390380		
39	DELIVERY ROOM & LABOR ROOM	.183568		
40	ANESTHESIOLOGY	.211853		
41	RADIOLOGY-DIAGNOSTIC	.176788	46,016	8,135
44	LABORATORY	.288624	91,160	26,311
49	RESPIRATORY THERAPY	.453339	132,567	60,098
50	PHYSICAL THERAPY	.415689	335,572	139,494
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	1.077573		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217	165	142
56	DRUGS CHARGED TO PATIENTS	.425155	161,233	68,549
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.671273		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.649425		
63	OTHER OUTPATIENT SERVICE COST CENTER	.635273	7,265	4,615
	OTHER REIMBURS COST CNTRS			
101	TOTAL		773,978	307,344
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		773,978	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 2/27/2008
 I 15-1320 I FROM 10/ 1/2006 I WORKSHEET D-4
 I COMPONENT NO: I TO 9/30/2007 I
 I 15-1320 I

TITLE XIX HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT
		TO CHARGES 1	CHARGES 2	COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		417,482	
26	INTENSIVE CARE UNIT			
31	SUBPROVIDER			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.390380	269,586	105,241
39	DELIVERY ROOM & LABOR ROOM	.183568		
40	ANESTHESIOLOGY	.211853	103,650	21,959
41	RADIOLOGY-DIAGNOSTIC	.176788	84,994	15,026
44	LABORATORY	.288624	106,085	30,619
49	RESPIRATORY THERAPY	.453339	34,262	15,532
50	PHYSICAL THERAPY	.415689	2,778	1,155
52	SPEECH PATHOLOGY			
53	ELECTROCARDIOLOGY	1.077573		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.859217	1,152	990
56	DRUGS CHARGED TO PATIENTS	.425155	93,328	39,679
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.671273	22,734	15,261
62	OBSERVATION BEDS (NON-DISTINCT PART)	.649425		
63	OTHER OUTPATIENT SERVICE COST CENTER	.635273		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		718,569	245,462
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		718,569	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,274,964
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS),	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,274,964
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 INSTRU)	3,307,714
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	32,224
18.01	CAH ACTUAL BILLED COINSURANCE	1,550,223
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,725,267
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,725,267
24	PRIMARY PAYER PAYMENTS	795
25	SUBTOTAL	1,724,472
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	433,249
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	433,249
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	419,241
28	SUBTOTAL	2,157,721
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	2,157,721
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,040,118
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	117,603
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,943,349		2,081,372
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	5/ 1/2007	50,390	5/ 1/2007	41,254
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .99				
SUBTOTAL		-50,390		-41,254
4 TOTAL INTERIM PAYMENTS		1,892,959		2,040,118
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE XVIII SUBPROVIDER 1

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		1,724,568		
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	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
ADJUSTMENTS TO PROGRAM	.99			
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		1,724,568		
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)				
SETTLEMENT TO PROVIDER	.01			
SETTLEMENT TO PROGRAM	.02			
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,462,397		
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	5/ 1/2007	19,720		
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		-19,720		NONE
4 TOTAL INTERIM PAYMENTS		1,442,677		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT				
AMOUNT (BALANCE DUE)	SETTLEMENT TO PROVIDER			
BASED ON COST REPORT (1)	SETTLEMENT TO PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,089,210	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	310,417	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,375	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,399,627	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,399,627	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,399,627	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	13,083	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,386,544	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,386,544	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,442,677	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-56,133	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

TITLE XIX 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)
- 2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)
- 3 ANCILLARY SERVICES (SEE INSTRUCTIONS)
- 4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED
TEACHING PROGRAM (SEE INSTRUCTIONS)
- 5 PROGRAM DAYS
- 6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM
(SEE INSTRUCTIONS)
- 7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL
METHOD ONLY
- 8 SUBTOTAL
- 9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)
- 10 SUBTOTAL
- 11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS
APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)
- 12 SUBTOTAL
- 13 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER
RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN
PROFESSIONAL SERVICES)
- 14 80% OF PART B COSTS
- 15 SUBTOTAL
- 16 OTHER ADJUSTMENTS (SPECIFY)
- 17 REIMBURSABLE BAD DEBTS
- 17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES
(SEE INSTRUCTIONS)
- 18 TOTAL
- 19 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)
- 20 INTERIM PAYMENTS
- 20.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)
- 21 BALANCE DUE PROVIDER/PROGRAM
- 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
I	15-1320	I	FROM 10/ 1/2006	I	2/27/2008
I	COMPONENT NO:	I	TO 9/30/2007	I	WORKSHEET E-3
I	15-M320	I		I	PART I

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS
SUBPROVIDER 1

1	INPATIENT HOSPITAL SERVICES (SEE INSTRUCTIONS)	
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)	
1.02	ENTER FROM THE PS&R, THE IRF PPS PAYMENT	
1.03	MEDICAID SSI RATIO (IRF PPS ONLY) (SEE INSTR.)	
1.04	INPATIENT REHABILITATION FACILITY LIP PAYMENTS (SEE INSTRUCTIONS)	
1.05	OUTLIER PAYMENTS	
1.06	TOTAL PPS PAYMENTS (SUM OF LINES 1.01, (1.02, 1.04 FOR COLUMNS 1 & 1.01), 1.05 AND 1.42)	
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	
	INPATIENT PSYCHIATRIC FACILITY (IPF)	
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, ECT, STOP-LOSS, AND MEDICAL EDUCATION PAYMENTS)	1,803,681
1.09	NET IPF PPS OUTLIER PAYMENTS	20,095
1.10	NET IPF PPS ECT PAYMENTS	
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004 (SEE INSTRUCTIONS)	
1.12	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.13	CURRENT YEARS UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.14	CURRENT YEARS UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	6.758904
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (LINE 1.15/1.16)) \text{ RAISED TO THE POWER OF } .5150 - 1\}$.	
1.18	MEDICAL EDUCATION ADJUSTMENT (LINE 1.08 MULTIPLIED BY LINE 1.17).	
1.19	ADJUSTED NET IPF PPS PAYMENTS (SUM OF LINES 1.08, 1.09, 1.10 AND 1.18)	1,823,776
1.20	STOP LOSS PAYMENT FLOOR (LINE 1 x 70%)	
1.21	ADJUSTED NET PAYMENT FLOOR (LINE 1.20 x THE APPROPRIATE FEDERAL BLEND PERCENTAGE)	
1.22	STOP LOSS ADJUSTMENT (IF LINE 1.21 IS GREATER THAN LINE 1.19 ENTER THE AMOUNT ON LINE 1.21 LESS LINE 1.19 OTHERWISE ENTER -0-)	
1.23	TOTAL IPF PPS PAYMENTS (SUM OF LINES 1.01, 1.19 AND 1.22)	1,823,776
	INPATIENT REHABILITATION FACILITY (IRF)	
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INST.)	
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTRUCTIONS)	
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INST.)	
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)	
1.40	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)	
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR $\{(1 + (LINE 1.39/1.40)) \text{ RAISED TO THE POWER OF } .9012 - 1\}$.	
1.42	MEDICAL EDUCATION ADJUSTMENT (LINE 1.02 MULTIPLIED BY LINE 1.41).	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL (SEE INSTRUCTIONS)	1,823,776
5	PRIMARY PAYER PAYMENTS	
6	SUBTOTAL	1,823,776
7	DEDUCTIBLES	88,080
8	SUBTOTAL	1,735,696
9	COINSURANCE	11,128
10	SUBTOTAL	1,724,568
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROF SERV)	
11.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
12	SUBTOTAL	1,724,568
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)	
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
15	OTHER ADJUSTMENTS (SPECIFY)	
15.99	OUTLIER RECONCILIATION ADJUSTMENT	
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SEE INSTRUCTIONS)	1,724,568
18	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
19	INTERIM PAYMENTS	1,724,568
19.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
20	BALANCE DUE PROVIDER/PROGRAM	
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

		IN LIEU OF FORM CMS-2552-96-E-3 (05/2007)			
I	PROVIDER NO:	I	PERIOD:	I	PREPARED 2/27/2008
I	15-1320	I	FROM 10/ 1/2006	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 9/30/2007	I	PART I
I	15-M320	I		I	

PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS AND LTCH PPS AND IPF PPS
SUBPROVIDER 1

- FI ONLY -----
- 50 ENTER THE ORIGINAL OUTLIER AMOUNT FROM E-3,I LN 1.05 (IRF)
OR 1.09 (IPF).
 - 51 ENTER THE OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
 - 52 ENTER THE INTEREST RATE USED TO CALCULATE THE TIME VALUE
OF MONEY. (SEE INSTRUCTIONS).
 - 53 ENTER THE TIME VALUE OF MONEY.

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,002,126
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,002,126
5	PRIMARY PAYER PAYMENTS	4,478
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,017,624
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 LIABLE 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	2,017,624
19	COST OF COVERED SERVICES	342,520
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,675,104
23	COINSURANCE	
24	SUBTOTAL	1,675,104
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	242,557
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	242,557
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	221,845
26	SUBTOTAL	1,917,661
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	1,917,661
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	1,892,959
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	24,702
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	151,329

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

	TITLE XIX	HOSPITAL	OTHER TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
			1	2
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES 476,833			
3	MEDICAL AND OTHER SERVICES 1,132,013			
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL 1,608,846			
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS			
	SUBTOTAL 1,608,846			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES 417,482			
11	ANCILLARY SERVICE CHARGES 4,096,067			
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 4,513,549			
	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) 4,513,549			
24	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST 2,904,703			
25	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
26	COST OF COVERED SERVICES 1,608,846			
	PROSPECTIVE PAYMENT AMOUNT			
27	OTHER THAN OUTLIER PAYMENTS			
28	OUTLIER PAYMENTS			
29	PROGRAM CAPITAL PAYMENTS			
30	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
31	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
32	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
33	SUBTOTAL 1,608,846			
34	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
35	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE			
36	XVIII ENTER AMOUNT FROM LINE 30 1,608,846			
37	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
38	EXCESS OF REASONABLE COST			
39	SUBTOTAL 1,608,846			
40	COINSURANCE			
41	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
42	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
43	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
44	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
45	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
46	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
47	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
48	UTILIZATION REVIEW			
49	SUBTOTAL (SEE INSTRUCTIONS) 1,608,846			
50	INPATIENT ROUTINE SERVICE COST			
51	MEDICARE INPATIENT ROUTINE CHARGES			
52	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
53	PAYMENT FOR SERVICES ON A CHARGE BASIS			
54	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
55	FOR PAYMENT OF PART A SERVICES			
56	RATIO OF LINE 43 TO 44			
57	TOTAL CUSTOMARY CHARGES			
58	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
59	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
60	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
61	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
62	OTHER ADJUSTMENTS (SPECIFY)			
63	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
64	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
65	SUBTOTAL 1,608,846			
66	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
67	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
68	TOTAL AMOUNT PAYABLE TO THE PROVIDER 1,608,846			
69	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
70	INTERIM PAYMENTS 338,634			
71	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
72	BALANCE DUE PROVIDER/PROGRAM 1,270,212			
73	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			
74	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	4,767,834			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,467,311			
5	OTHER RECEIVABLES				
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	1,132,594			
8	PREPAID EXPENSES				
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	11,367,739			
FIXED ASSETS					
12	LAND	220,245			
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	7,147,497			
14	LESS ACCUMULATED DEPRECIATION				
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	7,367,742			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	13,581,264			
26	TOTAL OTHER ASSETS	13,581,264			
27	TOTAL ASSETS	32,316,745			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
LIABILITIES AND FUND BALANCE				
CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE			
	274,709			
29	SALARIES, WAGES & FEES PAYABLE			
	910,993			
30	PAYROLL TAXES PAYABLE			
31	NOTES AND LOANS PAYABLE (SHORT TERM)			
32	DEFERRED INCOME			
33	ACCELERATED PAYMENTS			
34	DUE TO OTHER FUNDS			
35	OTHER CURRENT LIABILITIES	623,658		
36	TOTAL CURRENT LIABILITIES	1,809,360		
LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE			
38	NOTES PAYABLE			
39	UNSECURED LOANS			
40.01	LOANS PRIOR TO 7/1/66			
40.02	ON OR AFTER 7/1/66			
41	OTHER LONG TERM LIABILITIES			
42	TOTAL LONG-TERM LIABILITIES			
43	TOTAL LIABILITIES	1,809,360		
CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	30,507,385		
45	SPECIFIC PURPOSE FUND			
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	30,507,385		
52	TOTAL LIABILITIES AND FUND BALANCES	32,316,745		

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		27,457,110		
2 NET INCOME (LOSS)		3,062,275		
3 TOTAL		30,519,385		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		30,519,385		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 OTHER		13,000		
14				
15				
16				
17				
18 TOTAL DEDUCTIONS		13,000		
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		30,506,385		

	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				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 OTHER				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I IN LIEU OF FORM CMS-2552-96 (09/1996)
 I PROVIDER NO: 15-1320 I PERIOD: FROM 10/1/2006 TO 9/30/2007 I PREPARED 2/27/2008 I WORKSHEET G-2 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
2 00 HOSPITAL	3,864,749		3,864,749
4 00 SUBPROVIDER			
5 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	3,864,749		3,864,749
10 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 INTENSIVE CARE UNIT			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,864,749		3,864,749
17 00 ANCILLARY SERVICES	9,820,354	30,586,377	40,406,731
18 00 OUTPATIENT SERVICES			
24 00			
25 00 TOTAL PATIENT REVENUES	13,685,103	30,586,377	44,271,480

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		23,289,830	
ADD (SPECIFY)			
27 00			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		23,289,830	