

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

FORM APPROVED  
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH  
CARE COMPLEX  
COST REPORT CERTIFICATION  
AND SETTLEMENT SUMMARY

I PROVIDER NO: 15-1302  
I PERIOD FROM 7/ 1/2006  
I TO 6/30/2007  
I

I INTERMEDIARY USE ONLY  
I --AUDITED --DESK REVIEW  
I --INITIAL --REOPENED  
I --FINAL 1-MCR CODE  
I 00 - # OF REOPENINGS

WORKSHEET S  
PARTS I & II  
I DATE RECEIVED:  
I / /  
I INTERMEDIARY NO:  
I

ELECTRONICALLY FILED COST REPORT DATE: 11/28/2007 TIME 8:32

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:  
BLACKFORD COMMUNITY HOSPITAL 15-1302  
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2006 AND ENDING 6/30/2007 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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ECR ENCRYPTION INFORMATION  
DATE: 11/28/2007 TIME 8:32  
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*Ats. J. White*  
\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

*President*  
\_\_\_\_\_  
TITLE

*11/29/07*  
\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX
1	HOSPITAL	0	-197,124	3	66,568
3	SWING BED - SNF	0	-256,773	0	0
100	TOTAL	0	-453,897	-381,483	66,568

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: 530 EAST VAN SLEAVE STREET P.O. BOX:  
 1.01 CITY: HARTFORD CITY STATE: IN ZIP CODE: 47348- COUNTY: BLACKFORD

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	BLACKFORD COMMUNITY HOSPITAL	15-1302	2.01	2/ 1/2000	N 0 0
04.00 SWING BED - SNF	BLACKFORD COMMUNITY SWINGBED	15-2302		2/ 1/2000	N 0 0

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

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 2  
 20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS). N

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION DATE / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2.

25 IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R? N

25.01 IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?

25.02 IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.

25.03 AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.

25.04 ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I. N

25.05 HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.

26.01 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 2/ 1/2000

28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02				
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1	2	3	4
		-----	-----	-----	-----
		0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)				
		%	Y/N		
28.03	STAFFING	0.00%			
28.04	RECRUITMENT	0.00%			
28.05	RETENTION	0.00%			
28.06	TRAINING	0.00%			
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N			
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y			
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N			
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N			
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N			
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N			
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N			
	MISCELLANEOUS COST REPORT INFORMATION				
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N			
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N			
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N			
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N			
		V	XVIII	XIX	
	PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N	
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N	
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N	

TITLE XIX INPATIENT SERVICES

- 38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? 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 Y 158001  
 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? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 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 NHCQM DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF)  
 DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

- |  | PART A<br>1 | PART B<br>2 | OUTPATIENT<br>ASC<br>3 | OUTPATIENT<br>RADIOLOGY<br>4 | OUTPATIENT<br>DIAGNOSTIC<br>5 |
|--|-------------|-------------|------------------------|------------------------------|-------------------------------|
| 47.00 HOSPITAL   | N           | N           | N                      | N                            | N                             |
| 52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)  |             |             |                        |                              |                               |
| 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:<br>PREMIUMS: 0<br>PAID LOSSES: 0<br>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 SCHEDULE AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.   |             |             |                        |                              |                               |
| 56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULE AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.  |             |             |                        |                              | 0                             |
| 56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.   |             |             |                        |                              | 0                             |
| 56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.  |             |             |                        |                              | 0                             |
| 57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?   |             |             |                        |                              | N                             |
| 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.  |             |             |                        |                              | N                             |
| 58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). |             |             |                        |                              | 0                             |
| 59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)   |             |             |                        |                              | N                             |
| 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)   |             |             |                        |                              | N                             |
| 60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). |             |             |                        |                              | 0                             |

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / TITLE 3	O/P VISITS / TITLE 4	NOT LCH N/A	TRIPS 5
1 ADULTS & PEDIATRICS	15	5,475	131,400.00		1,400	4.01	85
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)					1,256		
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	15	5,475			2,656		85
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL	15	5,475			2,656		85
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
25 TOTAL	15						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION NOT ADMITTED 5.02	O/P VISITS / ALL PATS 6	TRIPS 6.01	OBSERVATION NOT ADMITTED 6.02	INTERNS & RES. FTES 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,902				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,256				
4 ADULTS & PED-SB NF			98				
5 TOTAL ADULTS AND PEDS			3,256				
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL			3,256				
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
25 TOTAL							
26 OBSERVATION BED DAYS			326		326		
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	DISCHARGES TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					368	25	530
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		123.42			368	25	530
13 RPCH VISITS							
18 HOME HEALTH AGENCY							
25 TOTAL		123.42					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
27 01 AMBULANCE TRIPS							
27 02 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

	COST CENTER	COST CENTER DESCRIPTION	SALARIES		OTHER	TOTAL	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5	
		GENERAL SERVICE COST CNTR						
3	0300	NEW CAP REL COSTS-BLDG & FIXT		1,818,816		1,818,816		1,818,816
5	0500	EMPLOYEE BENEFITS		1,040,908		1,040,908		1,040,908
6	0600	ADMINISTRATIVE & GENERAL	485,892	412,855		898,747		898,747
8	0800	OPERATION OF PLANT	108,674	349,618		458,292		458,292
9	0900	LAUNDRY & LINEN SERVICE						
10	1000	HOUSEKEEPING	140,632	106,062		246,694		246,694
11	1100	DIETARY	126,304	123,016		249,320	-182,377	66,943
12	1200	CAFETERIA					182,377	182,377
14	1400	NURSING ADMINISTRATION	182,081	13,515		195,596		195,596
17	1700	MEDICAL RECORDS & LIBRARY	66,960	78,165		145,125		145,125
		INPAT ROUTINE SRVC CNTRS						
25	2500	ADULTS & PEDIATRICS	798,691	53,116		851,807		851,807
26	2600	INTENSIVE CARE UNIT						
33	3300	NURSERY						
		ANCILLARY SRVC COST CNTRS						
37	3700	OPERATING ROOM	281,589	245,827		527,416		527,416
40	4000	ANESTHESIOLOGY		180,321		180,321		180,321
41	4100	RADIOLOGY-DIAGNOSTIC	393,864	554,868		948,732		948,732
41.01	4101	SLEEP LAB		45,057		45,057		45,057
44	4400	LABORATORY		1,095,794		1,095,794		1,095,794
46	4600	WHOLE BLOOD & PACKED RED BLOOD CELLS		39,824		39,824		39,824
49	4900	RESPIRATORY THERAPY		388,352		388,352		388,352
50	5000	PHYSICAL THERAPY		307,979		307,979		307,979
53	5300	ELECTROCARDIOLOGY	52,299	21,290		73,589		73,589
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,571	84,994		103,565		103,565
56	5600	DRUGS CHARGED TO PATIENTS	14,757	462,050		476,807		476,807
		OUTPAT SERVICE COST CNTRS						
61	6100	EMERGENCY	712,996	1,018,614		1,731,610		1,731,610
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)						
		OTHER REIMBURS COST CNTRS						
65	6500	AMBULANCE SERVICES	768,894	133,436		902,330		902,330
71	7100	HOME HEALTH AGENCY						
		SPEC PURPOSE COST CENTERS						
88	8800	INTEREST EXPENSE						
90	9000	OTHER CAPITAL RELATED COSTS						
95		SUBTOTALS	4,152,204	8,574,477		12,726,681	-0-	12,726,681
		NONREIMBURS COST CENTERS						
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN						
98	9800	PHYSICIANS' PRIVATE OFFICES	65,114	1,939		67,053		67,053
100	7950	OTHER NONREIMBURSABLE COST CENTERS						
100.01	7951	OTHER NONREIMBURSABLE COST CENTERS						
100.02	7952	PHARMACY						
101		TOTAL	4,217,318	8,576,416		12,793,734	-0-	12,793,734

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-188,205	1,630,611
5	0500 EMPLOYEE BENEFITS	-30,900	1,010,008
6	0600 ADMINISTRATIVE & GENERAL	3,113,096	4,011,843
8	0800 OPERATION OF PLANT	71,967	530,259
9	0900 LAUNDRY & LINEN SERVICE		
10	1000 HOUSEKEEPING	4,430	251,124
11	1100 DIETARY		66,943
12	1200 CAFETERIA	-65,181	117,196
14	1400 NURSING ADMINISTRATION		195,596
17	1700 MEDICAL RECORDS & LIBRARY	-4,329	140,796
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		851,807
26	2600 INTENSIVE CARE UNIT		
33	3300 NURSERY		
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		527,416
40	4000 ANESTHESIOLOGY	-156,984	23,337
41	4100 RADIOLOGY-DIAGNOSTIC		948,732
41.01	4101 SLEEP LAB		45,057
44	4400 LABORATORY	-45,765	1,050,029
46	4600 WHOLE BLOOD & PACKED RED BLOOD CELLS		39,824
49	4900 RESPIRATORY THERAPY	-17,416	370,936
50	5000 PHYSICAL THERAPY	-853	307,126
53	5300 ELECTROCARDIOLOGY		73,589
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		103,565
56	5600 DRUGS CHARGED TO PATIENTS		476,807
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-646,653	1,084,957
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
65	6500 AMBULANCE SERVICES		902,330
71	7100 HOME HEALTH AGENCY		
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	2,033,207	14,759,888
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		67,053
100	7950 OTHER NONREIMBURSABLE COST CENTERS		
100.01	7951 OTHER NONREIMBURSABLE COST CENTERS		
100.02	7952 PHARMACY		
101	TOTAL	2,033,207	14,826,941

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
41.01	SLEEP LAB	4101	RADIOLOGY-DIAGNOSTIC
44	LABORATORY	4400	
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	4600	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
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	
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	OTHER NONREIMBURSABLE COST CENTERS	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	OTHER NONREIMBURSABLE COST CENTERS	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	PHARMACY	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL	0000	

RECLASSIFICATIONS

PROVIDER NO: 151302	PERIOD: FROM 7/ 1/2006 TO 6/30/2007	PREPARED 11/27/2007 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	INCREASE		SALARY 4	OTHER 5
			LINE NO 3			
1 CAFETERIA	A	CAFETERIA	12		92,391	89,986
36 TOTAL RECLASSIFICATIONS					92,391	89,986

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

RECLASSIFICATIONS

PROVIDER NO:  
151302

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

PREPARED 11/27/2007  
WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF 10
			LINE NO				
1 CAFETERIA	1	6	7		8	9	
36 TOTAL RECLASSIFICATIONS	A	DIETARY	11		92,391	89,986	
					92,391	89,986	

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

RECLASSIFICATIONS

PROVIDER NO:  
151302

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

PREPARED 11/27/2007  
WORKSHEET A-6  
NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : CAFETERIA

		----- INCREASE -----		----- DECREASE -----		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	182,377	DIETARY	11	182,377
TOTAL RECLASSIFICATIONS FOR CODE A			182,377			182,377

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							
2 LAND IMPROVEMENTS							
3 BUILDINGS & FIXTURE							
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT							
6 MOVABLE EQUIPMENT							
7 SUBTOTAL							
8 RECONCILING ITEMS							
9 TOTAL							

PART III - RECONCILIATION OF CAPITAL COST CENTERS

* 3 5	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-BL								
	TOTAL				1.000000				

* 3 5	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
	NEW CAP REL COSTS-BL	2,064,091		-433,480				1,630,611
	TOTAL	2,064,091		-433,480				1,630,611

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

* 3 5	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
	NEW CAP REL COSTS-BL	1,818,816						1,818,816
	TOTAL	1,818,816						1,818,816

\* All lines numbers except line 5 are to be consistent with workshcet 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).

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	
	1	2	3	LINE NO	4
1			**COST CENTER DELETED**	1	
2			**COST CENTER DELETED**	2	
3			NEW CAP REL COSTS-BLDG &	3	
4			**COST CENTER DELETED**	4	
5					
6					
7					
8					
9					
10					
11					
12					
13	A-8-2	-713,253			
14					
15	A-8-1	3,486,560			
16					
17					
18					
19					
20					
21					
22					
23					
24					
25	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	A-8-3				
28			**COST CENTER DELETED**	89	
29			**COST CENTER DELETED**	1	
30			**COST CENTER DELETED**	2	
31			NEW CAP REL COSTS-BLDG &	3	
32			**COST CENTER DELETED**	4	
33			**COST CENTER DELETED**	20	
34					
35	A-8-4		**COST CENTER DELETED**	51	
36	A-8-4		**COST CENTER DELETED**	52	
37	B	-61,832	CAFETERIA	12	
38	B	-3,349	CAFETERIA	12	
39	B	-4,329	MEDICAL RECORDS & LIBRARY	17	
40	B	-4,488	ADMINISTRATIVE & GENERAL	6	
41	B	-7,808	NEW CAP REL COSTS-BLDG &	3	11
42	B	-4,314	ADMINISTRATIVE & GENERAL	6	
43	A	-90,384	ANESTHESIOLOGY	40	
44	A	-56,795	ADMINISTRATIVE & GENERAL	6	
45	A	-425,672	NEW CAP REL COSTS-BLDG &	3	11
46	A	-73,480	NEW CAP REL COSTS-BLDG &	3	9
47	A	-4,720	ADMINISTRATIVE & GENERAL	6	
48	A	-1,050	EMPLOYEE BENEFITS	5	
49	A	-335	NEW CAP REL COSTS-BLDG &	3	9
49.01	A	-1,544	ADMINISTRATIVE & GENERAL	6	
49.02					
49.03					
50		2,033,207			

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	6	ADMINISTRATIVE & GENERAL	1,957,574		1,957,574	
2	3	NEW CAP REL COSTS-BLDG & CAPITAL	238,305		238,305	9
3	3	NEW CAP REL COSTS-BLDG & CAPITAL LAB	55,304		55,304	9
4	44	LABORATORY	725,362	771,127	-45,765	
4.01	49	RESPIRATORY THERAPY	343,906	361,322	-17,416	
4.02	50	PHYSICAL THERAPY	263,559	264,412	-853	
4.03	5	EMPLOYEE BENEFITS	354,107	383,957	-29,850	
4.04	3	NEW CAP REL COSTS-BLDG & BMH CAPITAL	25,481		25,481	9
4.05						
4.06	6	ADMINISTRATIVE & GENERAL	1,227,383		1,227,383	
4.07	8	OPERATION OF PLANT	71,967		71,967	
4.08	10	HOUSEKEEPING	4,430		4,430	
4.09						
5		TOTALS	5,267,378	1,780,818	3,486,560	

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) NAME	PERCENTAGE OF OWNERSHIP	HOME OFFICE TYPE OF BUSINESS
1	2	3	4	5	6
1	B	CHS		100.00	0.00
2				0.00	0.00
3				0.00	0.00
4				0.00	0.00
5				0.00	0.00

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	40 ANESTHESIA PHYSICIAN FEE	66,600	66,600					
2	44 LABORATORY PHYSICIAN FEE	36,000		36,000				
3	61 EMERGENCY ROOM PHYSICIAN	979,778	646,653	333,125				
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,082,378	713,253	369,125				



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 260  
 (SEE INSTRUCTIONS)  
 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY  
 ASSISTANT WAS ON PROVIDER SITE BUT NEITHER  
 SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE 2  
 (SEE INSTRUCTIONS)  
 5 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)  
 6 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY  
 THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR  
 THERAPIST WAS NOT PRESENT DURING THE VISIT(S))  
 (SEE INSTRUCTIONS)  
 7 STANDARD TRAVEL EXPENSE RATE 4.52  
 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED	918.00	1372.00	491.00	2296.00	
10 AHSEA (SEE INSTRUCTIONS)	105.73	84.58	46.32	46.32	
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	42.29	42.29	23.16		
12 NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01 NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13 NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01 NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14 SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1,  
 LINE 10) 97,060  
 15 THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2,  
 LINE 10) 116,044  
 16 ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3,  
 LINE 10) 22,743  
 17 SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT  
 OR LINES 14-16 FOR ALL OTHERS ) 235,847  
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10) 106,351  
 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) 342,198

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) 342,198

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) 10,995  
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11) 46  
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 11,041  
 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES  
 3 AND 4) 1,184  
 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD  
 TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES  
 26 AND 27) 12,225  
 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) 12,225  
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL  
 EXPENSE (SUM OF LINES 27 AND 30)  
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL  
 EXPENSE (SUM OF LINES 31 AND 32)

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

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

PHYSICAL THERAPY

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

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)	1	2	3	4	5
48 OVERTIME RATE (SEE INSTRUCTIONS)					
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)	342,198
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	12,225
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)	354,423
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	208,029
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)	208,029
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)	208,029
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 BLACKFORD COMMUNITY HOSPITAL      IN LIEU OF FORM CMS-2552-96(12/1999)  
REASONABLE COST DETERMINATION FOR THERAPY      I PROVIDER NO:      I PERIOD:      I PREPARED 11/27/2007  
SERVICES FURNISHED BY OUTSIDE SUPPLIERS      I 15-1302      I FROM 7/ 1/2006      I WORKSHEET A-8-4  
ON OR AFTER APRIL 10, 1998      I      I TO 6/30/2007      I PARTS I - VII  
PHYSICAL THERAPY

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

RESPIRATORY THERAPY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 52  
 (SEE INSTRUCTIONS)  
 2 LINE 1 MULTIPLIED BY 15 HOURS PER WEEK 780  
 3 NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR 260  
 OR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY  
 ASSISTANT WAS ON PROVIDER SITE BUT NEITHER  
 SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 5 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)  
 6 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY  
 THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR  
 THERAPIST WAS NOT PRESENT DURING THE VISIT(S))  
 (SEE INSTRUCTIONS)  
 7 STANDARD TRAVEL EXPENSE RATE 4.52  
 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED		10535.00			
10 AHSEA (SEE INSTRUCTIONS)		66.49			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.25	33.25			
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) 700,472  
 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 ) 700,472  
 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) 700,472

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) 700,472

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

STANDARD TRAVEL ALLOWANCE  
 24 THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11) 8,645  
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)  
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 8,645  
 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES  
3 AND 4) 1,175  
 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD  
TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES  
26 AND 27) 9,820  
 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) 9,820  
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL  
EXPENSE (SUM OF LINES 27 AND 30)  
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL  
EXPENSE (SUM OF LINES 31 AND 32)

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

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

RESPIRATORY THERAPY

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

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
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)	700,472
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	9,820
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)	710,292
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	361,322
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)	361,322
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)	361,322
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 BLACKFORD COMMUNITY HOSPITAL      IN LIEU OF FORM CMS-2552-96(12/1999)  
REASONABLE COST DETERMINATION FOR THERAPY      I PROVIDER NO:      I PERIOD:      I PREPARED 11/27/2007  
SERVICES FURNISHED BY OUTSIDE SUPPLIERS      I 15-1302      I FROM 7/ 1/2006      I WORKSHEET A-8-4  
ON OR AFTER APRIL 10, 1998      I      I TO 6/30/2007      I PARTS I - VII  
RESPIRATORY THERAPY

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

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 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 250  
 (SEE INSTRUCTIONS)  
 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY  
 ASSISTANT WAS ON PROVIDER SITE BUT NEITHER  
 SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 5 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)  
 6 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY  
 THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR  
 THERAPIST WAS NOT PRESENT DURING THE VISIT(S))  
 (SEE INSTRUCTIONS)  
 7 STANDARD TRAVEL EXPENSE RATE 4.52  
 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9 TOTAL HOURS WORKED		849.00			
10 AHSEA (SEE INSTRUCTIONS)		58.55			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	29.28	29.28			
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) 49,709  
 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 ) 49,709  
 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) 49,709

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) 49,709

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) 7,320  
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)  
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 7,320  
 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES  
3 AND 4) 1,130  
 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD  
TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES  
26 AND 27) 8,450  
 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) 8,450  
 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)

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	49,709
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	8,450
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)	58,159
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	36,972
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)	36,972
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)	36,972
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 BLACKFORD COMMUNITY HOSPITAL      IN LIEU OF FORM CMS-2552-96(12/1999)  
I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007  
I 15-1302 I FROM 7/ 1/2006 I WORKSHEET A-8-4  
I I TO 6/30/2007 I PARTS I - VII

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

OCCUPATIONAL THERAPY

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

SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1 TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) 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 212  
 (SEE INSTRUCTIONS)  
 4 NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY  
 ASSISTANT WAS ON PROVIDER SITE BUT NEITHER  
 SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE  
 (SEE INSTRUCTIONS)  
 5 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)  
 6 NUMBER OF UNDUPLICATED OFFSITE VISITS -  
 THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY  
 THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR  
 THERAPIST WAS NOT PRESENT DURING THE VISIT(S))  
 (SEE INSTRUCTIONS)  
 7 STANDARD TRAVEL EXPENSE RATE 4.52  
 8 OPTIONAL TRAVEL EXPENSE RATE PER MILE

	SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
	1	2	3	4	5
9 TOTAL HOURS WORKED		453.00			
10 AHSEA (SEE INSTRUCTIONS)		56.27			
11 STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	28.14	28.14			
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) 25,490  
 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 ) 25,490  
 18 AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)  
 19 TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5,  
 LINE 10)  
 20 TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT  
 OR LINES 17 AND 18 FOR ALL OTHERS) 25,490

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 56.27  
 (SEE INSTRUCTIONS)  
 22 WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES 43,891  
 (SEE INSTRUCTIONS)  
 23 TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS) 43,891

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) 5,966  
 25 ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)  
 26 SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS) 5,966  
 27 STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES  
 3 AND 4) 958  
 28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD  
 TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES  
 26 AND 27) 6,924  
 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) 6,924  
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL  
 EXPENSE (SUM OF LINES 27 AND 30)  
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL  
 EXPENSE (SUM OF LINES 31 AND 32)

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

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

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	43,891
58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	6,924
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)	50,815
64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	19,411
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)	19,411
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)	19,411
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 BLACKFORD COMMUNITY HOSPITAL      IN LIEU OF FORM CMS-2552-96(12/1999)  
REASONABLE COST DETERMINATION FOR THERAPY      I PROVIDER NO:      I PERIOD:      I PREPARED 11/27/2007  
SERVICES FURNISHED BY OUTSIDE SUPPLIERS      I 15-1302      I FROM 7/ 1/2006      I WORKSHEET A-8-4  
ON OR AFTER APRIL 10, 1998      I      I TO 6/30/2007      I PARTS I - VII  
SPEECH PATHOLOGY

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

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	NOT ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEEET	ENTERED
9	LAUNDRY & LINEN SERVICE	3	POUNDS OF	LAUNDRY	NOT ENTERED
10	HOUSEKEEPING	4	SQUARE	FEEET	ENTERED
11	DIETARY	5	MEALS	SERVED	ENTERED
12	CAFETERIA	6	FTE'S		ENTERED
14	NURSING ADMINISTRATION	7	FTE'S		ENTERED
17	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	NOT ENTERED

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
	0	3	5	5a.00	6	8	9
GENERAL SERVICE COST CNTR				5a.00	6	8	9
003 NEW CAP REL COSTS-BLDG &	1,630,611	1,630,611					
005 EMPLOYEE BENEFITS	1,010,008		1,010,008				
006 ADMINISTRATIVE & GENERAL	4,011,843	273,273	116,367	4,401,483	4,401,483		
008 OPERATION OF PLANT	530,259	139,268	26,026	695,553	293,653	989,206	
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	251,124	20,428	33,680	305,232	128,865	16,590	
011 DIETARY	66,943	60,955	8,122	136,020	57,426	49,502	
012 CAFETERIA	117,196	40,746	22,127	180,069	76,023	33,090	
014 NURSING ADMINISTRATION	195,596	16,152	43,607	255,355	107,807	13,117	
017 MEDICAL RECORDS & LIBRARY	140,796	29,856	16,036	186,688	78,817	24,246	
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	851,807	306,344	191,278	1,349,429	569,710	248,787	
033 INTENSIVE CARE UNIT							
037 NURSERY							
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	527,416	209,504	67,438	804,358	339,589	170,140	
041 ANESTHESIOLOGY	23,337	2,814		26,151	11,041	2,285	
041 RADIOLOGY-DIAGNOSTIC	948,732	126,075	94,327	1,169,134	493,592	102,387	
041 01 SLEEP LAB	45,057			45,057	19,022		
044 LABORATORY	1,050,029	34,570		1,084,599	457,903	28,075	
046 WHOLE BLOOD & PACKED RED	39,824	3,947		43,771	18,480	3,205	
049 RESPIRATORY THERAPY	370,936	14,581		385,517	162,760	11,841	
050 PHYSICAL THERAPY	307,126	18,637		325,763	137,533	15,135	
053 ELECTROCARDIOLOGY	73,589	7,236	12,525	93,350	39,411	5,876	
055 MEDICAL SUPPLIES CHARGED	103,565	23,753	4,448	131,766	55,630	19,290	
056 DRUGS CHARGED TO PATIENTS	476,807	18,674	3,534	499,015	210,677	15,165	
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	1,084,957	124,139	170,756	1,379,852	582,552	100,814	
065 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES	902,330	87,705	184,143	1,174,178	495,722	71,226	
071 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	14,759,888	1,558,657	994,414	14,672,340	4,336,213	930,771	
096 NONREIMBURS COST CENTERS							
098 GIFT, FLOWER, COFFEE SHOP		8,734		8,734	3,687	7,093	
100 PHYSICIANS' PRIVATE OFFIC	67,053	63,220	15,594	145,867	61,583	51,342	
100 OTHER NONREIMBURSABLE COS							
100 01 OTHER NONREIMBURSABLE COS							
100 02 PHARMACY							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	14,826,941	1,630,611	1,010,008	14,826,941	4,401,483	989,206	

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007  
 I 15-1302 I FROM 7/ 1/2006 I WORKSHEET 8  
 I I TO 6/30/2007 I PART I

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMIN ISTRATION 14	MEDICAL RECOR DS & LIBRARY 17	SUBTOTAL 25	I&R COST POST STEP- DOWN ADJ 26
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
009 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	450,687						
011 DIETARY	24,750	267,698					
012 CAFETERIA	16,545		305,727				
014 NURSING ADMINISTRATION	6,559		14,022	396,860			
017 MEDICAL RECORDS & LIBRARY	12,123		10,002		311,876		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	124,389	267,698	78,783	193,692	20,679	2,853,167	
033 INTENSIVE CARE UNIT NURSERY							
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	85,069		17,145	42,153	25,543	1,483,997	
041 ANESTHESIOLOGY	1,143				1,059	41,679	
041 RADIOLOGY-DIAGNOSTIC	51,193		29,639		93,332	1,939,277	
041 01 SLEEP LAB					2,862	66,941	
044 LABORATORY	14,037				55,178	1,639,792	
046 WHOLE BLOOD & PACKED RED	1,603				1,078	68,137	
049 RESPIRATORY THERAPY	5,921				19,343	585,382	
050 PHYSICAL THERAPY	7,568				7,535	493,534	
053 ELECTROCARDIOLOGY	2,938		4,685	11,519	6,789	164,568	
055 MEDICAL SUPPLIES CHARGED	9,645		6,712		20,998	244,041	
056 DRUGS CHARGED TO PATIENTS	7,582		498		13,445	746,382	
061 OUTPAT SERVICE COST CNTRS							
061 EMERGENCY	50,406		53,696	132,014	15,411	2,314,745	
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS							
065 AMBULANCE SERVICES			83,434		28,624	1,853,184	
071 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	421,471	267,698	298,616	379,378	311,876	14,494,826	
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	3,546					23,060	
098 PHYSICIANS' PRIVATE OFFIC	25,670		7,111	17,482		309,055	
100 OTHER NONREIMBURSABLE COS							
100 01 OTHER NONREIMBURSABLE COS							
100 02 PHARMACY							
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	450,687	267,698	305,727	396,860	311,876	14,826,941	

## COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO:	I PERIOD:	I PREPARED 11/27/2007
I 15-1302	I FROM 7/ 1/2006	I WORKSHEET B
I	I TO 6/30/2007	I PART I

COST CENTER		TOTAL
DESCRIPTION		
		27
	GENERAL SERVICE COST CNTR	
003	NEW CAP REL COSTS-BLDG &	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
017	MEDICAL RECORDS & LIBRARY	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	2,853,167
026	INTENSIVE CARE UNIT	
033	NURSERY	
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	1,483,997
040	ANESTHESIOLOGY	41,679
041	RADIOLOGY-DIAGNOSTIC	1,939,277
041	01 SLEEP LAB	66,941
044	LABORATORY	1,639,792
046	WHOLE BLOOD & PACKED RED	68,137
049	RESPIRATORY THERAPY	585,382
050	PHYSICAL THERAPY	493,534
053	ELECTROCARDIOLOGY	164,568
055	MEDICAL SUPPLIES CHARGED	244,041
056	DRUGS CHARGED TO PATIENTS	746,382
	OUTPAT SERVICE COST CNTRS	
061	EMERGENCY	2,314,745
062	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
065	AMBULANCE SERVICES	1,853,184
071	HOME HEALTH AGENCY	
	SPEC PURPOSE COST CENTERS	
095	SUBTOTALS	14,494,826
	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	23,060
098	PHYSICIANS' PRIVATE OFFIC	309,055
100	OTHER NONREIMBURSABLE COS	
100	01 OTHER NONREIMBURSABLE COS	
100	02 PHARMACY	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	TOTAL	14,826,941

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007  
 I 15-1302 I FROM 7/ 1/2006 I WORKSHEET B  
 I I TO 6/30/2007 I PART III

	COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE
		0	3	4a	5	6	8	9
003	GENERAL SERVICE COST CNTR							
005	NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL		273,273	273,273		273,273		
008	OPERATION OF PLANT		139,268	139,268		18,232	157,500	
009	LAUNDRY & LINEN SERVICE							
010	HOUSEKEEPING		20,428	20,428		8,001	2,641	
011	DIETARY		60,955	60,955		3,565	7,882	
012	CAFETERIA		40,746	40,746		4,720	5,269	
014	NURSING ADMINISTRATION		16,152	16,152		6,693	2,089	
017	MEDICAL RECORDS & LIBRARY		29,856	29,856		4,893	3,860	
025	INPAT ROUTINE SRVC CNTRS							
026	ADULTS & PEDIATRICS		306,344	306,344		35,371	39,611	
033	INTENSIVE CARE UNIT							
033	NURSERY							
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		209,504	209,504		21,084	27,090	
040	ANESTHESIOLOGY		2,814	2,814		685	364	
041	RADIOLOGY-DIAGNOSTIC		126,075	126,075		30,645	16,302	
041	01 SLEEP LAB					1,181		
044	LABORATORY		34,570	34,570		28,430	4,470	
046	WHOLE BLOOD & PACKED RED		3,947	3,947		1,147	510	
049	RESPIRATORY THERAPY		14,581	14,581		10,105	1,885	
050	PHYSICAL THERAPY		18,637	18,637		8,539	2,410	
053	ELECTROCARDIOLOGY		7,236	7,236		2,447	936	
055	MEDICAL SUPPLIES CHARGED		23,753	23,753		3,454	3,071	
056	DRUGS CHARGED TO PATIENTS		18,674	18,674		13,080	2,415	
061	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY		124,139	124,139		36,171	16,051	
062	OBSERVATION BEDS (NON-DIS							
062	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES		87,705	87,705		30,778	11,340	
071	HOME HEALTH AGENCY							
071	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		1,558,657	1,558,657		269,221	148,196	
095	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		8,734	8,734		229	1,129	
098	PHYSICIANS' PRIVATE OFFIC		63,220	63,220		3,823	8,175	
100	OTHER NONREIMBURSABLE COS							
100	01 OTHER NONREIMBURSABLE COS							
100	02 PHARMACY							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		1,630,611	1,630,611		273,273	157,500	

COST CENTER DESCRIPTION	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMIN ISTRATION 14	MEDICAL RECOR DS & LIBRARY 17	SUBTOTAL 25	POST STEPPDOWN ADJUSTMENT 26
003 GENERAL SERVICE COST CNTR							
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL OPERATION OF PLANT							
008 LAUNDRY & LINEN SERVICE							
010 HOUSEKEEPING	31,070						
011 DIETARY	1,706	74,108					
012 CAFETERIA	1,141		51,876				
014 NURSING ADMINISTRATION	452			27,765			
017 MEDICAL RECORDS & LIBRARY	836		1,697		41,142		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	8,574	74,108	13,368	13,551	2,729	493,656	
033 INTENSIVE CARE UNIT NURSERY							
037 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	5,865		2,909	2,949	3,370	272,771	
041 ANESTHESIOLOGY	79				140	4,082	
041 RADIOLOGY-DIAGNOSTIC	3,529		5,029		12,304	193,884	
041 01 SLEEP LAB					378	1,559	
044 LABORATORY	968				7,281	75,719	
046 WHOLE BLOOD & PACKED RED	110				142	5,856	
049 RESPIRATORY THERAPY	408				2,552	29,531	
050 PHYSICAL THERAPY	522				994	31,102	
053 ELECTROCARDIOLOGY	203		795	806	896	13,319	
055 MEDICAL SUPPLIES CHARGED	665		1,139		2,771	34,853	
056 DRUGS CHARGED TO PATIENTS	523		85		1,774	36,551	
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	3,475		9,111	9,236	2,034	200,217	
065 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)							
071 AMBULANCE SERVICES			14,157		3,777	147,757	
095 HOME HEALTH AGENCY							
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	29,056	74,108	50,669	26,542	41,142	1,540,857	
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP	244					10,336	
098 PHYSICIANS' PRIVATE OFFIC	1,770		1,207	1,223		79,418	
100 OTHER NONREIMBURSABLE COS							
100 01 OTHER NONREIMBURSABLE COS							
100 02 PHARMACY							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	31,070	74,108	51,876	27,765	41,142	1,630,611	

## ALLOCATION OF NEW CAPITAL RELATED COSTS

I	PROVIDER	NO:	I	PERIOD:	I	PREPARED	11/27/2007
I	15-1302		I	FROM	7/ 1/2006	I	WORKSHEET B
I			I	TO	6/30/2007	I	PART III

COST CENTER DESCRIPTION		TOTAL
		27
	GENERAL SERVICE COST CNTR	
003	NEW CAP REL COSTS-BLDG &	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENERAL	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVICE	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATION	
017	MEDICAL RECORDS & LIBRARY	
	INPAT ROUTINE SRVC CNTRS	
025	ADULTS & PEDIATRICS	493,656
026	INTENSIVE CARE UNIT	
033	NURSERY	
	ANCILLARY SRVC COST CNTRS	
037	OPERATING ROOM	272,771
040	ANESTHESIOLOGY	4,082
041	RADIOLOGY-DIAGNOSTIC	193,884
041 01	SLEEP LAB	1,559
044	LABORATORY	75,719
046	WHOLE BLOOD & PACKED RED	5,856
049	RESPIRATORY THERAPY	29,531
050	PHYSICAL THERAPY	31,102
053	ELECTROCARDIOLOGY	13,319
055	MEDICAL SUPPLIES CHARGED	34,853
056	DRUGS CHARGED TO PATIENTS	36,551
	OUTPAT SERVICE COST CNTRS	
061	EMERGENCY	200,217
062	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
065	AMBULANCE SERVICES	147,757
071	HOME HEALTH AGENCY	
	SPEC PURPOSE COST CENTERS	
095	SUBTOTALS	1,540,857
	NONREIMBURS COST CENTERS	
096	GIFT, FLOWER, COFFEE SHOP	10,336
098	PHYSICIANS' PRIVATE OFFIC	79,418
100	OTHER NONREIMBURSABLE COS	
100 01	OTHER NONREIMBURSABLE COS	
100 02	PHARMACY	
101	CROSS FOOT ADJUSTMENTS	
102	NEGATIVE COST CENTER	
103	TOTAL	1,630,611

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	NEW CAP REL C	EMPLOYEE BENE	RECONCIL- IATION	ADMINISTRATIV	OPERATION OF	LAUNDRY & LIN
	OSTS-BLDG &	FITS		E & GENERAL	PLANT	EN SERVICE
	( SQUARE FEET )	( GROSS SALARIES )		( ACCUM. COST )	( SQUARE FEET )	( POUNDS OF LAUNDRY )
	3	5	6a.00	6	8	9
003 GENERAL SERVICE COST CNTR						
005 NEW CAP REL COSTS-BLDG & EMPLOYEE BENEFITS	44,621					
006 ADMINISTRATIVE & GENERAL	7,478	4,217,318				
008 OPERATION OF PLANT	3,811	485,892	-4,401,483	10,425,458		
009 LAUNDRY & LINEN SERVICE		108,674		695,553	33,332	
010 HOUSEKEEPING		559		305,232	559	
011 DIETARY	1,668	33,913		136,020	1,668	
012 CAFETERIA	1,115	92,391		180,069	1,115	
014 NURSING ADMINISTRATION		442		255,355	442	
017 MEDICAL RECORDS & LIBRARY		817		186,688	817	
025 INPAT ROUTINE SRVC CNTRS						
026 ADULTS & PEDIATRICS	8,383	798,691		1,349,429	8,383	
033 INTENSIVE CARE UNIT NURSERY						
037 ANCILLARY SRVC COST CNTRS						
040 OPERATING ROOM	5,733	281,589		804,358	5,733	
041 ANESTHESIOLOGY	77			26,151	77	
041 RADIOLOGY-DIAGNOSTIC	3,450	393,864		1,169,134	3,450	
041 01 SLEEP LAB				45,057		
044 LABORATORY	946			1,084,599	946	
046 WHOLE BLOOD & PACKED RED	108			43,771	108	
049 RESPIRATORY THERAPY	399			385,517	399	
050 PHYSICAL THERAPY	510			325,763	510	
053 ELECTROCARDIOLOGY	198	52,299		93,350	198	
055 MEDICAL SUPPLIES CHARGED	650	18,571		131,766	650	
056 DRUGS CHARGED TO PATIENTS	511	14,757		499,015	511	
061 OUTPAT SERVICE COST CNTRS						
062 EMERGENCY	3,397	712,996		1,379,852	3,397	
065 OBSERVATION BEDS (NON-DIS						
071 OTHER REIMBURS COST CNTRS						
065 AMBULANCE SERVICES	2,400	768,894		1,174,178	2,400	
071 HOME HEALTH AGENCY						
095 SPEC PURPOSE COST CENTERS						
095 SUBTOTALS	42,652	4,152,204	-4,401,483	10,270,857	31,363	
096 NONREIMBURS COST CENTERS						
098 GIFT, FLOWER, COFFEE SHOP	239			8,734	239	
100 PHYSICIANS' PRIVATE OFFIC	1,730	65,114		145,867	1,730	
100 01 OTHER NONREIMBURSABLE COS						
100 02 PHARMACY						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	1,630,611	1,010,008		4,401,483	989,206	
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	36.543578	.239491		.422186	29.677367	
105 (WRKSHT B, PT I)						
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED				273,273	157,500	
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER				.026212	4.725189	
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
	( SQUARE FEET )	( MEALS SERVED )	( FTE'S )	( FTE'S )	( GROSS CHARGES )
	10	11	12	14	17
003 GENERAL SERVICE COST CNTR					
005 NEW CAP REL COSTS-BLDG &					
006 EMPLOYEE BENEFITS					
008 ADMINISTRATIVE & GENERAL					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING	30,373				
012 DIETARY	1,668		100		
014 CAFETERIA	1,115			9,201	
017 NURSING ADMINISTRATION	442			422	4,858
025 MEDICAL RECORDS & LIBRARY	817			301	27,562,513
026 INPAT ROUTINE SRVC CNTRS					
033 ADULTS & PEDIATRICS	8,383		100	2,371	1,827,569
037 INTENSIVE CARE UNIT					
040 NURSERY					
041 ANCILLARY SRVC COST CNTRS					
041 OPERATING ROOM	5,733			516	516
041 ANESTHESIOLOGY	77				2,257,444
041 RADIOLOGY-DIAGNOSTIC	3,450			892	93,568
041 01 SLEEP LAB					8,247,879
044 LABORATORY	946				252,975
046 WHOLE BLOOD & PACKED RED	108				4,876,528
049 RESPIRATORY THERAPY	399				95,240
050 PHYSICAL THERAPY	510				1,709,488
053 ELECTROCARDIOLOGY	198			141	665,949
055 MEDICAL SUPPLIES CHARGED	650			202	600,009
056 DRUGS CHARGED TO PATIENTS	511			15	1,855,804
061 OUTPAT SERVICE COST CNTRS					1,188,276
062 EMERGENCY	3,397			1,616	1,616
065 OBSERVATION BEDS (NON-DIS					1,362,024
071 OTHER REIMBURS COST CNTRS					
065 AMBULANCE SERVICES				2,511	2,529,760
071 HOME HEALTH AGENCY					
095 SPEC PURPOSE COST CENTERS					
096 SUBTOTALS	28,404		100	8,987	4,644
098 NONREIMBURS COST CENTERS					27,562,513
100 GIFT, FLOWER, COFFEE SHOP	239				
100 PHYSICIANS' PRIVATE OFFIC	1,730			214	214
100 OTHER NONREIMBURSABLE COS					
100 01 OTHER NONREIMBURSABLE COS					
100 02 PHARMACY					
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 COST TO BE ALLOCATED	450,687	267,698	305,727	396,860	311,876
(PER WRKSHT B, PART I)					
104 UNIT COST MULTIPLIER		2,676.980000		81.692054	
(WRKSHT B, PT I)					
105 COST TO BE ALLOCATED	14.838409		33.227584		.011315
(PER WRKSHT B, PART II)					
106 UNIT COST MULTIPLIER					
(WRKSHT B, PT II)					
107 COST TO BE ALLOCATED	31,070	74,108	51,876	27,765	41,142
(PER WRKSHT B, PART III)					
108 UNIT COST MULTIPLIER		741.080000		5.715315	
(WRKSHT B, PT III)					
	1.022948		5.638083		.001493

## COMPUTATION OF RATIO OF COSTS TO CHARGES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/27/2007
I	15-1302	I	FROM 7/ 1/2006	I	WORKSHEET C
I		I	TO 6/30/2007	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	2,853,167		2,853,167		
26	INTENSIVE CARE UNIT					
33	NURSERY					
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,483,997		1,483,997		
40	ANESTHESIOLOGY	41,679		41,679		
41	RADIOLOGY-DIAGNOSTIC	1,939,277		1,939,277		
41 01	SLEEP LAB	66,941		66,941		
44	LABORATORY	1,639,792		1,639,792		
46	WHOLE BLOOD & PACKED RED	68,137		68,137		
49	RESPIRATORY THERAPY	585,382		585,382		
50	PHYSICAL THERAPY	493,534		493,534		
53	ELECTROCARDIOLOGY	164,568		164,568		
55	MEDICAL SUPPLIES CHARGED	244,041		244,041		
56	DRUGS CHARGED TO PATIENTS	746,382		746,382		
61	OUTPAT SERVICE COST CNTRS EMERGENCY	2,314,745		2,314,745		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	265,791		265,791		
65	AMBULANCE SERVICES	1,853,184		1,853,184		
101	SUBTOTAL	14,760,617		14,760,617		
102	LESS OBSERVATION BEDS	265,791		265,791		
103	TOTAL	14,494,826		14,494,826		

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/27/2007  
 I 15-1302 I FROM 7/ 1/2006 I WORKSHEET C  
 I I TO 6/30/2007 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
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	1,576,281		1,576,281			
33	INTENSIVE CARE UNIT						
	NURSERY						
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	377,562	1,879,882	2,257,444	.657379	.657379	
41	ANESTHESIOLOGY	9,992	83,576	93,568	.445441	.445441	
41	RADIOLOGY-DIAGNOSTIC	573,672	7,674,207	8,247,879	.235124	.235124	
44	01 SLEEP LAB		252,975	252,975	.264615	.264615	
46	LABORATORY	850,275	4,026,253	4,876,528	.336262	.336262	
49	WHOLE BLOOD & PACKED RED	40,715	54,525	95,240	.715424	.715424	
50	RESPIRATORY THERAPY	1,387,840	321,648	1,709,488	.342431	.342431	
53	PHYSICAL THERAPY	277,023	388,926	665,949	.741099	.741099	
55	ELECTROCARDIOLOGY	50,935	549,074	600,009	.274276	.274276	
56	MEDICAL SUPPLIES CHARGED	980,271	875,533	1,855,804	.131501	.131501	
	DRUGS CHARGED TO PATIENTS	736,763	451,513	1,188,276	.628122	.628122	
61	OUTPAT SERVICE COST CNTRS						
62	EMERGENCY	20,830	1,341,194	1,362,024	1.699489	1.699489	
	OBSERVATION BEDS (NON-DIS		251,288	251,288	1.057715	1.057715	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES		2,529,760	2,529,760	.732553	.732553	
101	SUBTOTAL	6,882,159	20,680,354	27,562,513			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,882,159	20,680,354	27,562,513			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,853,167		2,853,167		
26	INTENSIVE CARE UNIT					
33	NURSERY					
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,483,997		1,483,997		
40	ANESTHESIOLOGY	41,679		41,679		
41	RADIOLOGY-DIAGNOSTIC	1,939,277		1,939,277		
41 01	SLEEP LAB	66,941		66,941		
44	LABORATORY	1,639,792		1,639,792		
46	WHOLE BLOOD & PACKED RED	68,137		68,137		
49	RESPIRATORY THERAPY	585,382		585,382		
50	PHYSICAL THERAPY	493,534		493,534		
53	ELECTROCARDIOLOGY	164,568		164,568		
55	MEDICAL SUPPLIES CHARGED	244,041		244,041		
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	746,382		746,382		
61	EMERGENCY	2,314,745		2,314,745		
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	265,791		265,791		
65	AMBULANCE SERVICES	1,853,184		1,853,184		
101	SUBTOTAL	14,760,617		14,760,617		
102	LESS OBSERVATION BEDS	265,791		265,791		
103	TOTAL	14,494,826		14,494,826		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
26	ADULTS & PEDIATRICS	1,576,281		1,576,281			
33	INTENSIVE CARE UNIT						
	NURSERY						
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM	377,562	1,879,882	2,257,444	.657379	.657379	
41	ANESTHESIOLOGY	9,992	83,576	93,568	.445441	.445441	
41	RADIOLOGY-DIAGNOSTIC	573,672	7,674,207	8,247,879	.235124	.235124	
41	SLEEP LAB		252,975	252,975	.264615	.264615	
44	LABORATORY	850,275	4,026,253	4,876,528	.336262	.336262	
46	WHOLE BLOOD & PACKED RED	40,715	54,525	95,240	.715424	.715424	
49	RESPIRATORY THERAPY	1,387,840	321,648	1,709,488	.342431	.342431	
50	PHYSICAL THERAPY	277,023	388,926	665,949	.741099	.741099	
53	ELECTROCARDIOLOGY	50,935	549,074	600,009	.274276	.274276	
55	MEDICAL SUPPLIES CHARGED	980,271	875,533	1,855,804	.131501	.131501	
56	DRUGS CHARGED TO PATIENTS	736,763	451,513	1,188,276	.628122	.628122	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	20,830	1,341,194	1,362,024	1.699489	1.699489	
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS		251,288	251,288	1.057715	1.057715	
65	AMBULANCE SERVICES		2,529,760	2,529,760	.732553	.732553	
101	SUBTOTAL	6,882,159	20,680,354	27,562,513			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,882,159	20,680,354	27,562,513			

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	1,483,997	272,771	1,211,226			1,483,997
40	ANESTHESIOLOGY	41,679	4,082	37,597			41,679
41	RADIOLOGY-DIAGNOSTIC	1,939,277	193,884	1,745,393			1,939,277
41 01	SLEEP LAB	66,941	1,559	65,382			66,941
44	LABORATORY	1,639,792	75,719	1,564,073			1,639,792
46	WHOLE BLOOD & PACKED RED	68,137	5,856	62,281			68,137
49	RESPIRATORY THERAPY	585,382	29,531	555,851			585,382
50	PHYSICAL THERAPY	493,534	31,102	462,432			493,534
53	ELECTROCARDIOLOGY	164,568	13,319	151,249			164,568
55	MEDICAL SUPPLIES CHARGED	244,041	34,853	209,188			244,041
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	746,382	36,551	709,831			746,382
61	EMERGENCY	2,314,745	200,217	2,114,528			2,314,745
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	265,791		265,791			265,791
65	AMBULANCE SERVICES	1,853,184	147,757	1,705,427			1,853,184
101	SUBTOTAL	11,907,450	1,047,201	10,860,249			11,907,450
102	LESS OBSERVATION BEDS	265,791		265,791			265,791
103	TOTAL	11,641,659	1,047,201	10,594,458			11,641,659

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT & COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,257,444	.657379	.657379
40	ANESTHESIOLOGY	93,568	.445441	.445441
41	RADIOLOGY-DIAGNOSTIC	8,247,879	.235124	.235124
41 01	SLEEP LAB	252,975	.264615	.264615
44	LABORATORY	4,876,528	.336262	.336262
46	WHOLE BLOOD & PACKED RED	95,240	.715424	.715424
49	RESPIRATORY THERAPY	1,709,488	.342431	.342431
50	PHYSICAL THERAPY	665,949	.741099	.741099
53	ELECTROCARDIOLOGY	600,009	.274276	.274276
55	MEDICAL SUPPLIES CHARGED	1,855,804	.131501	.131501
56	DRUGS CHARGED TO PATIENTS	1,188,276	.628122	.628122
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,362,024	1.699489	1.699489
62	OBSERVATION BEDS (NON-DIS	251,288	1.057715	1.057715
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,529,760	.732553	.732553
101	SUBTOTAL	25,986,232		
102	LESS OBSERVATION BEDS	251,288		
103	TOTAL	25,734,944		

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	1,483,997	272,771	1,211,226			1,483,997
40	ANESTHESIOLOGY	41,679	4,082	37,597			41,679
41	RADIOLOGY-DIAGNOSTIC	1,939,277	193,884	1,745,393			1,939,277
41 01	SLEEP LAB	66,941	1,559	65,382			66,941
44	LABORATORY	1,639,792	75,719	1,564,073			1,639,792
46	WHOLE BLOOD & PACKED RED	68,137	5,856	62,281			68,137
49	RESPIRATORY THERAPY	585,382	29,531	555,851			585,382
50	PHYSICAL THERAPY	493,534	31,102	462,432			493,534
53	ELECTROCARDIOLOGY	164,568	13,319	151,249			164,568
55	MEDICAL SUPPLIES CHARGED	244,041	34,853	209,188			244,041
56	DRUGS CHARGED TO PATIENTS	746,382	36,551	709,831			746,382
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	2,314,745	200,217	2,114,528			2,314,745
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	265,791		265,791			265,791
65	AMBULANCE SERVICES	1,853,184	147,757	1,705,427			1,853,184
101	SUBTOTAL	11,907,450	1,047,201	10,860,249			11,907,450
102	LESS OBSERVATION BEDS	265,791		265,791			265,791
103	TOTAL	11,641,659	1,047,201	10,594,458			11,641,659

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	2,257,444	.657379	.657379
40	ANESTHESIOLOGY	93,568	.445441	.445441
41	RADIOLOGY-DIAGNOSTIC	8,247,879	.235124	.235124
41	01 SLEEP LAB	252,975	.264615	.264615
44	LABORATORY	4,876,528	.336262	.336262
46	WHOLE BLOOD & PACKED RED	95,240	.715424	.715424
49	RESPIRATORY THERAPY	1,709,488	.342431	.342431
50	PHYSICAL THERAPY	665,949	.741099	.741099
53	ELECTROCARDIOLOGY	600,009	.274276	.274276
55	MEDICAL SUPPLIES CHARGED	1,855,804	.131501	.131501
56	DRUGS CHARGED TO PATIENTS	1,188,276	.628122	.628122
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,362,024	1.699489	1.699489
62	OBSERVATION BEDS (NON-DIS	251,288	1.057715	1.057715
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	2,529,760	.732553	.732553
101	SUBTOTAL	25,986,232		
102	LESS OBSERVATION BEDS	251,288		
103	TOTAL	25,734,944		

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	.657379		.657379		
40 ANESTHESIOLOGY	.445441		.445441		
41 RADIOLOGY-DIAGNOSTIC	.235124		.235124		
41 01 SLEEP LAB	.264615		.264615		
44 LABORATORY	.336262		.336262		
46 WHOLE BLOOD & PACKED RED BLOOD CELLS	.715424		.715424		
49 RESPIRATORY THERAPY	.342431		.342431		
50 PHYSICAL THERAPY	.741099		.741099		
53 ELECTROCARDIOLOGY	.274276		.274276		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.131501		.131501		
56 DRUGS CHARGED TO PATIENTS	.628122		.628122		
61 OUTPAT SERVICE COST CNTRS					
61 EMERGENCY	1.699489		1.699489		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.057715		1.057715		
65 OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES	.732553		.732553		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		652,302			
40 ANESTHESIOLOGY		34,875			
41 RADIOLOGY-DIAGNOSTIC		2,817,184			
41 01 SLEEP LAB					
44 LABORATORY		1,723,563			
46 WHOLE BLOOD & PACKED RED BLOOD CELLS		28,928			
49 RESPIRATORY THERAPY		171,564			
50 PHYSICAL THERAPY		122,125			
53 ELECTROCARDIOLOGY		274,347			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		347,127			
56 DRUGS CHARGED TO PATIENTS		199,364			
OUTPAT SERVICE COST CNTRS					
61 EMERGENCY		362,908			
62 OBSERVATION BEDS (NON-DISTINCT PART)		143,306			
OTHER REIMBURS COST CNTRS					
65 AMBULANCE SERVICES					
101 SUBTOTAL		6,877,593			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		6,877,593			

(A) WORKSHEET A LINE NUMBERS

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





TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,582
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,228
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,228
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	519
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)	737
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	40
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)	58
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,400
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	519
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)	737
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	125.93
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.18
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,853,167
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	5,037
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	7,608
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,036,662
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,816,505

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,576,281
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,576,281
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.152399
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	707.49
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,816,505

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 815.30  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,141,420  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,141,420

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
43 INTENSIVE CARE TYPE INPATIENT					
44 HOSPITAL UNITS					
45 INTENSIVE CARE UNIT					
46 CORONARY CARE UNIT					
47 BURN INTENSIVE CARE UNIT					
48 SURGICAL INTENSIVE CARE UNIT					
49 OTHER SPECIAL CARE					
					1
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					924,306
49 TOTAL PROGRAM INPATIENT COSTS					2,065,726

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) 423,141  
 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST  
 REPORTING PERIOD (SEE INSTRUCTIONS) 600,876  
 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS 1,024,017  
 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	326
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	815.31
85	OBSERVATION BED COST	265,791

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 SNF OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

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

SWING-BED ADJUSTMENT

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

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

TITLE XVIII PART A SNF OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,582
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,228
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,228
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	519
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)	737
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	40
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)	58
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	85
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 TITLES 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	125.93
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.18
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,853,167
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	5,037
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	7,608
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,036,662
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,816,505

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,576,281
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,576,281
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.152399
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	707.49
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,816,505

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 815.30  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 69,301  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 69,301

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42 NURSERY (TITLE V & XIX ONLY)					
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					91,985 161,286

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

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	326
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	815.31
85	OBSERVATION BED COST	265,791

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

WKST A LINE NO.	TITLE XVIII, PART A COST CENTER DESCRIPTION	HOSPITAL	OTHER		
			RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			869,826	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS				
37	OPERATING ROOM		.657379	160,647	105,606
40	ANESTHESIOLOGY		.445441	5,667	2,524
41	RADIOLOGY-DIAGNOSTIC		.235124	318,705	74,935
41 01	SLEEP LAB		.264615		
44	LABORATORY		.336262	497,989	167,455
46	WHOLE BLOOD & PACKED RED BLOOD CELLS		.715424	16,862	12,063
49	RESPIRATORY THERAPY		.342431	730,639	250,193
50	PHYSICAL THERAPY		.741099	41,306	30,612
53	ELECTROCARDIOLOGY		.274276	34,673	9,510
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		.131501	521,808	68,618
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS		.628122	322,313	202,452
61	EMERGENCY		1.699489	199	338
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS		1.057715		
65	AMBULANCE SERVICES				
101	TOTAL			2,650,808	924,306
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES				
103	NET CHARGES			2,650,808	

TITLE XVIII, PART A SWING BED SNF OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.657379	2,899	1,906
40	ANESTHESIOLOGY	.445441		
41	RADIOLOGY-DIAGNOSTIC	.235124	72,108	16,954
41 01	SLEEP LAB	.264615		
44	LABORATORY	.336262	187,286	62,977
46	WHOLE BLOOD & PACKED RED BLOOD CELLS	.715424	6,566	4,697
49	RESPIRATORY THERAPY	.342431	455,508	155,980
50	PHYSICAL THERAPY	.741099	212,607	157,563
53	ELECTROCARDIOLOGY	.274276	3,828	1,050
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.131501	140,264	18,445
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.628122	261,080	163,990
61	EMERGENCY	1.699489		
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.057715		
65	AMBULANCE SERVICES			
101	TOTAL		1,342,146	583,562
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,342,146	



PART 8 - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 2,870,709  
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,  
 2001 (SEE INSTRUCTIONS).  
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.  
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.  
 1.04 LINE 1.01 TIMES LINE 1.03.  
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.  
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)  
 1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9,  
 9.01, 9.02) LINE 101.  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 2,870,709

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR  
 PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE  
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT  
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 2,899,416  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 26,855  
 18.01 CAH ACTUAL BILLED COINSURANCE 1,029,247  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 1,843,314  
 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 1,843,314  
 24 PRIMARY PAYER PAYMENTS 2,160  
 25 SUBTOTAL 1,841,154

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 229,061  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 229,061  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES 182,896  
 28 SUBTOTAL 2,070,215  
 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 2,070,215  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 2,451,698  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM -381,483  
 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	2,037,699	3	2,583,735
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		50,491		
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				132,037
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		50,491		-132,037
4 TOTAL INTERIM PAYMENTS		2,088,190		2,451,698
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 .53				
TENTATIVE TO PROGRAM .54				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

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



TITLE XVIII      SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	1,034,257	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	589,398	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	1,256	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,623,655	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,623,655	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,623,655	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	46,046	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,577,609	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,577,609	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,834,382	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-256,773	
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	PART B
		1	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.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,065,726
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,065,726
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,086,383
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	
19	COST OF COVERED SERVICES	2,086,383
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	242,687
21	EXCESS REASONABLE COST	
22	SUBTOTAL	1,843,696
23	COINSURANCE	3,442
24	SUBTOTAL	1,840,254
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	50,812
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	50,812
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	38,382
26	SUBTOTAL	1,891,066
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	1,891,066
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,088,190
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	-197,124
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

## CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/27/2007
I	15-1302	I	FROM 7/ 1/2006	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 6/30/2007	I	PART III
I	-	I		I	

## 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	161,286	
3	MEDICAL AND OTHER SERVICES		
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
7	SUBTOTAL	161,286	
8	INPATIENT PRIMARY PAYER PAYMENTS		
9	OUTPATIENT PRIMARY PAYER PAYMENTS		
	SUBTOTAL	161,286	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES		
11	ANCILLARY SERVICE CHARGES	246,656	
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	246,656	
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	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)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	246,656	
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	85,370	
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES	161,286	
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL	161,286	
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30	161,286	
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL	161,286	
36	COINSURANCE		
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)	161,286	
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL	161,286	
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	161,286	
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS	94,718	
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM	66,568	
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		





	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2
1 FUND BALANCE AT BEGINNING		-848,042
2 OF PERIOD		
3 NET INCOME (LOSS)		315,160
4 TOTAL		-532,882
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		-532,882
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		-532,882
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5	6
1 FUND BALANCE AT BEGINNING		
2 OF PERIOD		
3 NET INCOME (LOSS)		
4 TOTAL		
5 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		
PERIOD PER BALANCE SHEET		

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
4 00 HOSPITAL	1,195,453		1,195,453
5 00 SWING BED - SNF	382,327		382,327
9 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	1,577,780		1,577,780
10 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 INTENSIVE CARE UNIT			
16 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	1,577,780		1,577,780
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	1,577,780		1,577,780
18 00 ANCILLARY SERVICES	5,332,665	22,791,096	28,123,761
19 00 OUTPATIENT SERVICES			
20 00 HOME HEALTH AGENCY			
24 00 AMBULANCE SERVICES			
25 00 TOTAL PATIENT REVENUES	6,910,445	22,791,096	29,701,541

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		12,793,734	
ADD (SPECIFY)			
27 00 BAD DEBT	1,443,371		
28 00 HOME OFFICE	1,754,660		
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		3,198,031	
DEDUCT (SPECIFY)			
34 00			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		15,991,765	

## STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/27/2007
I	15-1302	I	FROM 7/ 1/2006	I	WORKSHEET G-3
I		I	TO 6/30/2007	I	

DESCRIPTION		
1	TOTAL PATIENT REVENUES	29,701,541
2	LESS: ALLOWANCES AND DISCOUNTS ON	13,513,936
3	NET PATIENT REVENUES	16,187,605
4	LESS: TOTAL OPERATING EXPENSES	15,991,765
5	NET INCOME FROM SERVICE TO PATIENT	195,840
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	33,200
7	INCOME FROM INVESTMENTS	7,808
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	65,181
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	4,329
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	EDUCATION AND OTHER REVENUE	8,802
25	TOTAL OTHER INCOME	119,320
26	TOTAL	315,160
	OTHER EXPENSES	
27		
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	315,160