

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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-0019	I	FROM 9/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 8/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/10/2008 TIME 14:57

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:
SHELBY MEMORIAL HOSPITAL 14-0019
FOR THE COST REPORTING PERIOD BEGINNING 9/ 1/2007 AND ENDING 8/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/10/2008 TIME 14:57

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DATE: 11/10/2008 TIME 14:57

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2	3	4	5	6
1	HOSPITAL	0	68,792	-31,848	0	0
3	SWING BED - SNF	0	10,534	0	0	0
5	HOSPITAL-BASED SNF	0	0	0	0	0
7	HOSPITAL-BASED HHA	0	0	0	0	0
9	RHC	0	0	5,971	0	0
100	TOTAL	0	79,326	-25,877	0	0

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
 1 STREET: 200 SOUTH CEDAR P.O. BOX:
 1.01 CITY: SHELBYVILLE STATE: IL ZIP CODE: 62565-1899 COUNTY: SHELBY

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N) V XVIIIXIX		
					4	5	6
02.00	HOSPITAL	14-0019		7/ 1/1966	N	P	O
04.00	SWING BED - SNF	14-U019		4/13/1993	N	P	N
06.00	HOSPITAL-BASED SNF	14-5565		11/ 7/1986	N	P	N
09.00	HOSPITAL-BASED HHA	14-7622		8/ 3/1995	N	P	N
14.00	HOSPITAL-BASED RHC	14-3446		6/ 5/1998	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 9/ 1/2007 TO: 8/31/2008

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1
 20 SUBPROVIDER

OTHER INFORMATION

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

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

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

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

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

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

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER "Y" FOR YES, AND "N" FOR NO. 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 IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

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

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION IN COL. 3. / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COLUMN 3. / /

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

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

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

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

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

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

25.06 HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(c)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS) N N
 26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01.
 26.01 SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 1
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: 9/ 1/2007 ENDING: 8/31/2008
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. N 4/13/1996
 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 N
 28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS) 1 2 3 4
 28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY 100 0.8320 0.8335 0.00 2 14 99914

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	72.48%	Y
28.04 RECRUITMENT	0.00%	
28.05 RETENTION	0.00%	
28.06 TRAINING	0.00%	
28.07 OTHER	15.75%	Y
28.08	0.00%	
28.09	0.00%	
28.10	0.00%	
28.11	0.00%	
28.12	0.00%	
28.13	0.00%	
28.14	0.00%	
28.15	0.00%	
28.16	0.00%	
28.17	0.00%	
28.18	0.00%	
28.19	0.00%	
28.20	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) N
 30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70
 30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N
 30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N
 30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N
 31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N
 31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

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

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL
 36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) V XVIII XIX
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE 1 2 3
 N Y N

WITH 42 CFR 412.320? (SEE INSTRUCTIONS) N N N
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES

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

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

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

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

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

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	N	N	N	N	N
49.00 SNF	N	N			
50.00 HHA	N	N			

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
 52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
 53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
 53.01 MDH PERIOD: BEGINNING: / / ENDING: / /

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
 PREMIUMS: 197,056
 PAID LOSSES: 0
 AND/OR SELF INSURANCE: 0
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

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

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.

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

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N
 58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

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

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) 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).

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MULTICAMPUS

61.00 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00					0.00
62.01					0.00
62.02					0.00
62.03					0.00
62.04					0.00
62.05					0.00
62.06					0.00
62.07					0.00
62.08					0.00
62.09					0.00

HOSPITAL AND HOSPITAL HEALTH CARE
COMPLEX STATISTICAL DATA

PROVIDER NO: 14-0019
PERIOD: FROM 9/1/2007 TO 8/31/2008
PREPARED 11/6/2008
WORKSHEET S-3
PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH N/A 2.01	I/P DAYS / TITLE 3	O/P VISITS / TITLE 4	TRIPS / TOTAL 5
1 ADULTS & PEDIATRICS	30	10,980			2,328	368
2 HMO						
2 01 HMO - (IRF PPS SUBPROVIDER)						
3 ADULTS & PED-SB SNF					1,793	
4 ADULTS & PED-SB NF						94
5 TOTAL ADULTS AND PEDS	30	10,980			4,121	462
12 TOTAL	30	10,980			4,121	462
13 RPCH VISITS						
15 SKILLED NURSING FACILITY	15	5,490			573	
18 HOME HEALTH AGENCY					2,447	531
24 RURAL HEALTH CLINIC					1,716	
25 TOTAL	45					
26 OBSERVATION BED DAYS						36
27 AMBULANCE TRIPS						
28 EMPLOYEE DISCOUNT DAYS						
28 01 EMP DISCOUNT DAYS -IRF						

COMPONENT	TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS / TOTAL ALL PATS 6	TRIPS / TOTAL OBSERVATION BEDS ADMITTED 6.01	O/P VISITS / TOTAL OBSERVATION BEDS NOT ADMITTED 6.02	INTERNS & RES. FTES / TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			3,104				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			1,793				
4 ADULTS & PED-SB NF			94				
5 TOTAL ADULTS AND PEDS			4,991				
12 TOTAL			4,991				
13 RPCH VISITS							
15 SKILLED NURSING FACILITY			5,004				
18 HOME HEALTH AGENCY			3,139				
24 RURAL HEALTH CLINIC			6,281				
25 TOTAL							
26 OBSERVATION BED DAYS	8	28	186	55	131		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES / NET 9	--- FULL TIME EMPLOYEES ON PAYROLL 10	EQUIV NONPAID WORKERS 11	DISCHARGES / TITLE V 12	DISCHARGES / TITLE XVIII 13	DISCHARGES / TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					780	117	1,064
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		166.34			780	117	1,064
13 RPCH VISITS							
15 SKILLED NURSING FACILITY		1.68					
18 HOME HEALTH AGENCY		12.43					
24 RURAL HEALTH CLINIC		11.40					
25 TOTAL		191.85					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

HOSPITAL WAGE INDEX INFORMATION

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-3
 I I TO 8/31/2008 I PARTS II & III

PART II - WAGE DATA	AMOUNT REPORTED 1	RECLASS OF SALARIES 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	DATA SOURCE 6
SALARIES						
1 TOTAL SALARY	5,528,139		5,528,139	399,048.66	13.85	
2 NON-PHYSICIAN ANESTHETIST PART A						
3 NON-PHYSICIAN ANESTHETIST PART B						
4 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
5 PHYSICIAN - PART B	231,963		231,963	4,320.00	53.70	
5.01 NON-PHYSICIAN - PART B						
6 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
7 HOME OFFICE PERSONNEL						
8 SNF	401,908		401,908	28,170.39	14.27	
8.01 EXCLUDED AREA SALARIES	245,115	19,388	264,503	27,549.25	9.60	
OTHER WAGES & RELATED COSTS						
9 CONTRACT LABOR:	291,854		291,854	6,375.00	45.78	
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A	317,814		317,814	4,786.00	66.40	
10.01 TEACHING PHYSICIAN UNDER CONTRACT (SEE INSTRUCTIONS)						
11 HOME OFFICE SALARIES & WAGE RELATED COSTS						
12 HOME OFFICE: PHYS PART A						
12.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
WAGE RELATED COSTS						
13 WAGE-RELATED COSTS (CORE)	1,436,234		1,436,234			CMS 339
14 WAGE-RELATED COSTS (OTHER)						CMS 339
15 EXCLUDED AREAS	236,060		236,060			CMS 339
16 NON-PHYS ANESTHETIST PART A						CMS 339
17 NON-PHYS ANESTHETIST PART B						CMS 339
18 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
19 PHYSICIAN PART B	18,302		18,302			CMS 339
19.01 WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
20 INTERNS & RESIDENTS (APPRVD)						CMS 339
OVERHEAD COSTS - DIRECT SALARIES						
21 EMPLOYEE BENEFITS		43,484	43,484	2,165.00	20.08	
22 ADMINISTRATIVE & GENERAL	839,820	-43,484	796,336	40,407.68	19.71	
22.01 A & G UNDER CONTRACT						
23 MAINTENANCE & REPAIRS	223,317		223,317	24,782.81	9.01	
24 OPERATION OF PLANT						
25 LAUNDRY & LINEN SERVICE	17,566		17,566	2,261.50	7.77	
26 HOUSEKEEPING	219,306	-19,388	199,918	22,316.33	8.96	
26.01 HOUSEKEEPING UNDER CONTRACT						
27 DIETARY	210,237	-94,596	115,641	11,508.27	10.05	
27.01 DIETARY UNDER CONTRACT						
28 CAFETERIA		94,596	94,596	9,414.00	10.05	
29 MAINTENANCE OF PERSONNEL						
30 NURSING ADMINISTRATION	312,459		312,459	12,716.50	24.57	
31 CENTRAL SERVICE AND SUPPLY	89,633		89,633	6,330.98	14.16	
32 PHARMACY						
33 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	198,839		198,839	17,607.78	11.29	
34 SOCIAL SERVICE						
35 OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	5,296,176		5,296,176	394,728.66	13.42	
2 EXCLUDED AREA SALARIES	647,023	19,388	666,411	55,719.64	11.96	
3 SUBTOTAL SALARIES	4,649,153	-19,388	4,629,765	339,009.02	13.66	
4 SUBTOTAL OTHER WAGES & RELATED COSTS	609,668		609,668	11,161.00	54.62	
5 SUBTOTAL WAGE-RELATED COSTS	1,436,234		1,436,234		31.02	
6 TOTAL	6,695,055	-19,388	6,675,667	350,170.02	19.06	
7 NET SALARIES						
8 EXCLUDED AREA SALARIES						
9 SUBTOTAL SALARIES						
10 SUBTOTAL OTHER WAGES & RELATED COSTS						
11 SUBTOTAL WAGE-RELATED COSTS						
12 TOTAL						
13 TOTAL OVERHEAD COSTS	2,111,177	-19,388	2,091,789	149,510.85	13.99	

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-4
I HHA NO: I TO 8/31/2008 I
I 14-7622 I
COUNTY: I

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	1,236	55	145
2 UNDUPLICATED CENSUS COUNT		136.00	6.00	16.00
	TOTAL 5			
1 HOME HEALTH AIDE HOURS	1,436			
2 UNDUPLICATED CENSUS COUNT				
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)				

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK

HHA NO. OF FTE EMPLOYEES (2080 HRS)

	STAFF 1	CONTRACT 2	TOTAL 3
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)	1.16		1.16
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5 OTHER ADMINISTRATIVE PERSONEL	1.09		1.09
6 DIRECTING NURSING SERVICE	1.72		1.72
7 NURSING SUPERVISOR			
8 PHYSICAL THERAPY SERVICE	.81		.81
9 PHYSICAL THERAPY SUPERVISOR			
10 OCCUPATIONAL THERAPY SERVICE			
11 OCCUPATIONAL THERAPY SUPERVISOR			
12 SPEECH PATHOLOGY SERVICE			
13 SPEECH PATHOLOGY SUPERVISOR			
14 MEDICAL SOCIAL SERVICE			
15 MEDICAL SOCIAL SERVICE SUPERVISOR			
16 HOME HEALTH AIDE	.70		.70
17 HOME HEALTH AIDE SUPERVISOR			
18			
HOME HEALTH AGENCY MSA CODES	1	1.01	
19 HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	1	0	
20 LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).	9914		

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	FULL EPISODES			
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21 SKILLED NURSING VISITS	767	0	20	8
22 SKILLED NURSING VISIT CHARGES	95,875	0	2,500	1,000
23 PHYSICAL THERAPY VISITS	935	0	0	14
24 PHYSICAL THERAPY VISIT CHARGES	126,224	0	0	1,890
25 OCCUPATIONAL THERAPY VISITS	9	0	0	6
26 OCCUPATIONAL THERAPY VISIT CHARGES	1,440	0	0	960
27 SPEECH PATHOLOGY VISITS	7	0	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	1,050	0	0	0
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31 HOME HEALTH AIDE VISITS	663	0	0	10
32 HOME HEALTH AIDE VISIT CHARGES	43,095	0	0	650
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	2,381	0	20	38
34 OTHER CHARGES	0	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	267,684	0	2,500	4,500
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	133	0	9	1
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	2,687	0	134	0

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-4
I HHA NO: I TO 8/31/2008 I
I 14-7622 I
COUNTY: I

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21 SKILLED NURSING VISITS	0	7	802
22 SKILLED NURSING VISIT CHARGES	0	875	100,250
23 PHYSICAL THERAPY VISITS	0	1	950
24 PHYSICAL THERAPY VISIT CHARGES	0	135	128,249
25 OCCUPATIONAL THERAPY VISITS	0	0	15
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	2,400
27 SPEECH PATHOLOGY VISITS	0	0	7
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	1,050
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	673
32 HOME HEALTH AIDE VISIT CHARGES	0	0	43,745
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	8	2,447
34 OTHER CHARGES	0	0	0
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	1,010	275,694
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	1	144
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	2,821

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-7
I I TO 8/31/2008 I

GROUP(1) 1	M3PI REVENUE CODE 2	SERVICES PRIOR TO 10/1 RATE 3	10/1 DAYS 3.01	SERVICES ON/AFTER 10/1 RATE 4	10/1 DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE 4.02	9/30/01 DAYS 4.03
1	RUC						
2	RUB						
3	RUA						
3 .01	RUX						
3 .02	RUL						
4	RVC						
5	RVB						
6	RVA						
6 .01	RVX						
6 .02	RVL						
7	RHC		86				
8	RHB						
9	RHA						
9 .01	RHX						
9 .02	RHL						
10	RMC		55				
11	RMB		92				
12	RMA						
12 .01	RMX		83				
12 .02	RML		145				
13	RLB						
14	RLA						
14 .01	RLX		9				
15	SE3		5				
16	SE2		74				
17	SE1						
18	SSC						
19	SSB						
20	SSA						
21	CC2						
22	CC1						
23	CB2						
24	CB1		22				
25	CA2						
26	CA1						
27	IB2						
28	IB1						
29	IA2						
30	IA1						
31	BB2						
32	BB1						
33	BA2						
34	BA1						
35	PE2						
36	PE1						
37	PD2						
38	PD1						
39	PC2						
40	PC1						
41	PB2						
42	PB1						
43	PA2						
44	PA1						
45	Default		2				
46	TOTAL		573				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8320
 Wage Index Factor (after 10/01): 0.8335
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-7
I TO 8/31/2008 I

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2)		SWING BED SNF DAYS	TOTAL
			RUGs	DAYS		
	1	2	4.05	4.06		5
1	RUC					
2	RUB					
3	RUA					
3	.01 RUX					
3	.02 RUL					
4	RVC					
5	RVB					
6	RVA					
6	.01 RVX					
6	.02 RVL					
7	RHC					
8	RHB					
9	RHA				8	
9	.01 RHX					
9	.02 RHL					
10	RMC					
11	RMB				41	
12	RMA				129	
12	.01 RMX				217	
12	.02 RML				568	
13	RLB					
14	RLA					
14	.01 RLX					
15	SE3				367	
16	SE2				169	
17	SE1				4	
18	SSC					
19	SSB					
20	SSA				272	
21	CC2					
22	CC1					
23	CB2					
24	CB1					
25	CA2					
26	CA1				18	
27	IB2					
28	IB1					
29	IA2					
30	IA1					
31	BB2					
32	BB1					
33	BA2					
34	BA1					
35	PE2					
36	PE1					
37	PD2					
38	PD1					
39	PC2					
40	PC1					
41	PB2					
42	PB1					
43	PA2					
44	PA1					
45	Default					
46	TOTAL				1,793	

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8320
 Wage Index Factor (after 10/01) : 0.8335
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

PROVIDER NO:
14-0019

PERIOD: 9/ 1/2007 I PREPARED 11/ 6/2008
FROM 8/31/2008 I WORKSHEET 5-7
TO NOT A CMS WORKSHEET
SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	SERVICES BASE RATE	PRIOR TO RATE	OCTOBER 1ST DAYS	SERVICES BASE RATE	ON OR AFTER RATE	OCTOBER 1ST DAYS
1	RUC		458.21			478.65		
2	RUB		423.86			442.78		
3	RUA		406.10			424.23		
3	.01 RUX		531.62			555.34		
3	.02 RUL		472.41			493.49		
4	RVC		361.85			378.00		
5	RVB		345.27			360.68		
6	RVA		313.30			327.29		
6	.01 RVX		398.56			416.34		
6	.02 RVL		373.70			390.37		
7	RHC		310.08	310.08	86	323.91		
8	RHB		297.06			310.31		
9	RHA		276.93			289.28		
9	.01 RHX		333.76			348.65		
9	.02 RHL		327.84			342.47		
10	RMC		283.49	283.49	55	296.13		
11	RMB		276.38	276.38	92	288.72		
12	RMA		270.46			282.53		
12	.01 RMX		375.84	375.84	83	392.62		
12	.02 RML		346.24	346.24	145	361.69		
13	RLB		245.70			256.66		
14	RLA		211.37			220.79		
14	.01 RLX		265.84	265.84	9	277.69		
15	SE3		297.80	297.80	5	311.09		
16	SE2		253.99	253.99	74	265.33		
17	SE1		226.75			236.87		
18	SSC		223.20			233.17		
19	SSB		211.36			220.79		
20	SSA		207.81			217.09		
21	CC2		222.01			231.93		
22	CC1		203.07			212.13		
23	CB2		193.60			202.24		
24	CB1		185.31	185.31	22	193.58		
25	CA2		184.12			192.34		
26	CA1		172.28			179.97		
27	IB2		165.18			172.55		
28	IB1		162.81			170.08		
29	IA2		149.79			156.47		
30	IA1		143.86			150.28		
31	BB2		163.99			171.32		
32	BB1		159.26			166.37		
33	BA2		148.60			155.24		
34	BA1		139.13			145.34		
35	PE2		178.21			186.16		
36	PE1		174.65			182.45		
37	PD2		169.92			177.50		
38	PD1		167.55			175.03		
39	PC2		161.63			168.85		
40	PC1		159.26			166.37		
41	PB2		142.69			149.05		
42	PB1		141.50			147.81		
43	PA2		140.31			146.57		
44	PA1		136.76			142.87		
45	Default		136.76	136.76	2	142.87		
46	TOTAL				573			

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

Worksheet S-2 reference data:
 Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8320
 Wage Index Factor (after 10/01): 0.8335
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

Non-CMS S-7 options selected:
 Calculate Total Days from this worksheet.
 Transfer total to settlement worksheet.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-7
I I TO 8/31/2008 I NOT A CMS WORKSHEET
SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	A I D S		DIAGNOSIS		CODE	042		SWING BED SNF DAYS	TOTAL
			SERV PRIOR TO	OCT. 1ST DAYS	SERV ON/AFTER	OCT. 1ST DAYS	RATE	RATE			
	1	2	4.02	4.03			4.04	4.05	4.06	5	
1	RUC		1,044.72				1,091.32				
2	RUB		966.40				1,009.54				
3	RUA		925.91				967.24				
3	.01 RUX		1,212.09				1,266.18				
3	.02 RUL		1,077.09				1,125.16				
4	RVC		825.02				861.84				
5	RVB		787.22				822.35				
6	RVA		714.32				746.22				
6	.01 RVX		908.72				949.26				
6	.02 RVL		852.04				890.04				
7	RHC		706.98				738.51			26,667	
8	RHB		677.30				707.51				
9	RHA		631.40				659.56		8		
9	.01 RHX		760.97				794.92				
9	.02 RHL		747.48				780.83				
10	RMC		646.36				675.18			15,592	
11	RMB		630.15				658.28		41	25,427	
12	RMA		616.65				644.17		129		
12	.01 RMX		856.92				895.17		217	31,195	
12	.02 RML		789.43				824.65		568	50,205	
13	RLB		560.20				585.18				
14	RLA		481.92				503.40				
14	.01 RLX		606.12				633.13			2,393	
15	SE3		678.98				709.29		367	1,489	
16	SE2		579.10				604.95		169	18,795	
17	SE1		516.99				540.06		4		
18	SSC		508.90				531.63				
19	SSB		481.90				503.40				
20	SSA		473.81				494.97		272		
21	CC2		506.18				528.80				
22	CC1		463.00				483.66				
23	CB2		441.41				461.11				
24	CB1		422.51				441.36			4,077	
25	CA2		419.79				438.54				
26	CA1		392.80				410.33		18		
27	IB2		376.61				393.41				
28	IB1		371.21				387.78				
29	IA2		341.52				356.75				
30	IA1		328.00				342.64				
31	BB2		373.90				390.61				
32	BB1		363.11				379.32				
33	BA2		338.81				353.95				
34	BA1		317.22				331.38				
35	PE2		406.32				424.44				
36	PE1		398.20				415.99				
37	PD2		387.42				404.70				
38	PD1		382.01				399.07				
39	PC2		368.52				384.98				
40	PC1		363.11				379.32				
41	PB2		325.33				339.83				
42	PB1		322.62				337.01				
43	PA2		319.91				334.18				
44	PA1		311.81				325.74				
45	Default		311.81				325.74			274	
46	TOTAL								1,793	176,114	

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

Worksheet S-2 reference data:

Transition Period : 100% Federal
 Wage Index Factor (before 10/01): 0.8320
 Wage Index Factor (after 10/01): 0.8335
 SNF Facility Specific Rate : 0.00
 Urban/Rural Designation : RURAL
 SNF MSA Code : 14
 SNF CBSA Code : 99914

Non-CMS S-7 options selected:

[x] Calculate Total Days from this worksheet.
 [] Transfer total to settlement worksheet.

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 200 SOUTH CEDAR
 1.01 CITY: SHELBYVILLE STATE: IL ZIP CODE: 62565 COUNTY: SHELBY
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	ARNOLD AGAPITO, MD	1467421677
9.01 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DEBRA YOUCK, FNP	1578522561

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	ARNOLD AGAPITO, MD	40.00

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY			
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO		
12 CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14
			800	1700	800	1700	800	1700	800	1700	800	1700	800	1700		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

17 HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET S-10
 I I TO 8/31/2008 I
 I I I

DESCRIPTION

UNCOMPENSATED CARE INFORMATION		
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04		
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
UNCOMPENSATED CARE REVENUES		
17	REVENUE FROM UNCOMPENSATED CARE	2,626,201
17.01	GROSS MEDICAID REVENUES	
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,626,201
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	2,626,201
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.455997
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	1,197,540
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	

HOSPITAL UNCOMPENSATED CARE DATA

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET S-10
I		I	TO 8/31/2008	I	
I		I		I	

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	1,197,540
	(SUM OF LINES 25, 27, AND 29)	

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I PROVIDER NO:
I 14-0019
I

I PERIOD:
I FROM 9/ 1/2007
I TO 8/31/2008

I PREPARED 11/ 6/2008
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
3	0300 GENERAL SERVICE COST CNTR					
4	0400 NEW CAP REL COSTS-BLDG & FIXT		1,168,505	1,168,505	-323,192	845,313
5	0500 EMPLOYEE BENEFITS				690,709	690,709
6	0600 ADMINISTRATIVE & GENERAL	839,820	1,690,596	1,690,596	175,164	1,865,760
7	0700 MAINTENANCE & REPAIRS	223,317	1,183,645	2,023,465	-218,220	1,805,245
8	0800 OPERATION OF PLANT		105,290	328,607	-2,675	325,932
9	0900 LAUNDRY & LINEN SERVICE	17,566	347,891	347,891	-17,600	330,291
10	1000 HOUSEKEEPING	219,306	25,041	42,607		42,607
11	1100 DIETARY	210,237	16,825	236,131	-19,388	216,743
12	1200 CAFETERIA		256,053	466,290	-209,806	256,484
14	1400 NURSING ADMINISTRATION	312,459	10,502	322,961	209,778	209,778
15	1500 CENTRAL SERVICES & SUPPLY	89,633	20,209	109,842		322,961
17	1700 MEDICAL RECORDS & LIBRARY	198,839	32,918	231,757	-8,097	101,745
20	2000 NONPHYSICIAN ANESTHETISTS		35,336	35,336		231,757
	INPAT ROUTINE SRVC CNTRS					35,336
25	2500 ADULTS & PEDIATRICS	738,586	266,475	1,005,061		1,005,061
34	3400 SKILLED NURSING FACILITY	401,908	74,520	476,428	-362	476,066
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	81,231	59,235	140,466	-12,360	128,106
40	4000 ANESTHESIOLOGY		1,284	1,284		1,284
41	4100 RADIOLOGY-DIAGNOSTIC	269,313	618,528	887,841	5,400	893,241
44	4400 LABORATORY	430,764	531,132	961,896		961,896
49	4900 RESPIRATORY THERAPY	163,562	99,997	263,559	-26,204	237,355
50	5000 PHYSICAL THERAPY	220,662	42,847	263,509		263,509
50.01	5001 CARDIAC REHAB	23,850	1,251	25,101		25,101
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		20,899	20,899	26,204	47,103
56	5600 DRUGS CHARGED TO PATIENTS		1,062,105	1,062,105	3,725	1,065,830
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	113,702	16,511	130,213	-4,896	125,317
61	6100 EMERGENCY	268,711	810,829	1,079,540		1,079,540
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	383,605	28,356	411,961	-3,966	407,995
	OTHER REIMBURS COST CNTRS					
66	6600 DURABLE MEDICAL EQUIP-RENTED	75,953	135,796	211,749	-8,136	203,613
71	7100 HOME HEALTH AGENCY	245,115	62,981	308,096	-5,187	302,909
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		300,941	300,941	-300,941	
90	9000 OTHER CAPITAL RELATED COSTS					
95	SUBTOTALS	5,528,139	9,026,498	14,554,637	-50,050	14,504,587
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800 PHYSICIANS' PRIVATE OFFICES		1,127	1,127	50,050	51,177
100	7950 OTHER NONREIMBURSABLE COST CENTERS					
100.01	7951 FARM EXPENSE		10,763	10,763		10,763
100.02	7952 UNOCCUPIED SPACE					
101	TOTAL	5,528,139	9,038,388	14,566,527	-0-	14,566,527

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSESI PROVIDER NO:
I 14-0019
II PERIOD:
I FROM 9/ 1/2007
I TO 8/31/2008
II PREPARED 11/ 6/2008
I WORKSHEET A
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS 6	NET EXPENSES FOR ALLOC 7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-301,791	543,522
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		690,709
5	0500 EMPLOYEE BENEFITS	-1,076,547	789,213
6	0600 ADMINISTRATIVE & GENERAL	-136,549	1,668,696
7	0700 MAINTENANCE & REPAIRS		325,932
8	0800 OPERATION OF PLANT		330,291
9	0900 LAUNDRY & LINEN SERVICE		42,607
10	1000 HOUSEKEEPING		216,743
11	1100 DIETARY		256,484
12	1200 CAFETERIA	-48,197	161,581
14	1400 NURSING ADMINISTRATION		322,961
15	1500 CENTRAL SERVICES & SUPPLY		101,745
17	1700 MEDICAL RECORDS & LIBRARY	-11,298	220,459
20	2000 NONPHYSICIAN ANESTHETISTS	-35,336	
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-38	1,005,023
34	3400 SKILLED NURSING FACILITY	-1,280	474,786
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM		128,106
40	4000 ANESTHESIOLOGY		1,284
41	4100 RADIOLOGY-DIAGNOSTIC		893,241
44	4400 LABORATORY		961,896
49	4900 RESPIRATORY THERAPY	-61,825	175,530
50	5000 PHYSICAL THERAPY		263,509
50.01	5001 CARDIAC REHAB		25,101
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,347	44,756
56	5600 DRUGS CHARGED TO PATIENTS		1,065,830
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC	-846	124,471
61	6100 EMERGENCY	-459,702	619,838
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		407,995
	OTHER REIMBURS COST CNTRS		
66	6600 DURABLE MEDICAL EQUIP-RENTED	-3,163	200,450
71	7100 HOME HEALTH AGENCY	-55,277	247,632
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
90	9000 OTHER CAPITAL RELATED COSTS		-0-
95	SUBTOTALS	-2,194,196	12,310,391
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800 PHYSICIANS' PRIVATE OFFICES		51,177
100	7950 OTHER NONREIMBURSABLE COST CENTERS		
100.01	7951 FARM EXPENSE		10,763
100.02	7952 UNOCCUPIED SPACE		
101	TOTAL	-2,194,196	12,372,331

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I NOT A CMS WORKSHEET
 I I TO 8/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
17	MEDICAL RECORDS & LIBRARY	1700	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
50.01	CARDIAC REHAB	5001	PHYSICAL THERAPY
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
66	DURABLE MEDICAL EQUIP-RENTED	6600	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	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	FARM EXPENSE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	UNOCCUPIED SPACE	7952	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED 11/ 6/2008
140019	FROM 9/ 1/2007	WORKSHEET A-6
	TO 8/31/2008	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	INCREASE		
			LINE NO	SALARY	OTHER
	1	2	3	4	5
1 MEDICAL CENTER RECLASS	A	PHYSICIANS' PRIVATE OFFICES	98	19,388	
2 FIRE INSURANCE RECLASS	B	OTHER CAPITAL RELATED COSTS	90		16,925
3		PHYSICIANS' PRIVATE OFFICES	98		1,358
4 TELEPHONE EXPENSE RECLASS	C	ADMINISTRATIVE & GENERAL	6		20,583
5					
6					
7					
8					
9					
10 EMPLOYEE BENEFIT EXPENSE RECLASS	D	EMPLOYEE BENEFITS	5	43,484	131,680
11 RENTAL EXPENSE RECLASS	E	NEW CAP REL COSTS-MVBLE EQUIP	4		23,483
12		RADIOLOGY-DIAGNOSTIC	41		5,400
13					
14					
15					
16					
17					
18 MEDICAL CENTER UTILITIES RECLASS	F	PHYSICIANS' PRIVATE OFFICES	98		17,600
19 PHYSICIAN BUILDING DEPRECIATION REC	G	PHYSICIANS' PRIVATE OFFICES	98		11,704
20					
21 DEPRECIATION EXPENSE RECLASS	H	NEW CAP REL COSTS-MVBLE EQUIP	4		650,747
22 PROPERTY INSURANCE RECLASS	I	OTHER CAPITAL RELATED COSTS	90		25,470
23 CAFETERIA EXPENSE RECLASS	J	CAFETERIA	12	94,596	115,210
24 HHA EXPENSE RECLASS	K	ADMINISTRATIVE & GENERAL	6		576
25		RURAL HEALTH CLINIC	63.50		576
26 PPO ADMINISTRATIVE RECLASS	L	ADMINISTRATIVE & GENERAL	6		31
27 ONCOLOGY PHARMACY COST RECLASS	M	DRUGS CHARGED TO PATIENTS	56		4,148
28 INTEREST EXPENSE RECLASS	N	NEW CAP REL COSTS-BLDG & FIXT	3		300,941
29 REAL ESTATE TAX RECLASS	O	OTHER CAPITAL RELATED COSTS	90		12,402
30 TO RECLASS MEDICAL SUPPLY EXPENSE	P	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		26,204
36 TOTAL RECLASSIFICATIONS				157,468	1,365,038

(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:	PERIOD:	PREPARED 11/ 6/2008
140019	FROM 9/ 1/2007	WORKSHEET A-6
	TO 8/31/2008	

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF
			LINE NO	7			
1 MEDICAL CENTER RECLASS	A	HOUSEKEEPING	10		19,388		
2 FIRE INSURANCE RECLASS	B	ADMINISTRATIVE & GENERAL	6			18,283	
3							
4 TELEPHONE EXPENSE RECLASS	C	CENTRAL SERVICES & SUPPLY	15			7,763	
5		DRUGS CHARGED TO PATIENTS	56			423	
6		CLINIC	60			748	
7		RURAL HEALTH CLINIC	63.50			4,542	
8		DURABLE MEDICAL EQUIP-RENTED	66			3,072	
9		HOME HEALTH AGENCY	71			4,035	
10 EMPLOYEE BENEFIT EXPENSE RECLASS	D	ADMINISTRATIVE & GENERAL	6		43,484	131,680	12
11 RENTAL EXPENSE RECLASS	E	ADMINISTRATIVE & GENERAL	6			8,091	10
12		MAINTENANCE & REPAIRS	7			2,675	
13		CAFETERIA	12			28	
14		CENTRAL SERVICES & SUPPLY	15			334	
15		SKILLED NURSING FACILITY	34			362	
16		OPERATING ROOM	37			12,360	
17		DURABLE MEDICAL EQUIP-RENTED	66			5,033	
18 MEDICAL CENTER UTILITIES RECLASS	F	OPERATION OF PLANT	8			17,600	
19 PHYSICIAN BUILDING DEPRECIATION REC	G	NEW CAP REL COSTS-BLDG & FIXT	3			10,018	9
20		NEW CAP REL COSTS-MVBLE EQUIP	4			1,686	9
21 DEPRECIATION EXPENSE RECLASS	H	NEW CAP REL COSTS-BLDG & FIXT	3			650,747	9
22 PROPERTY INSURANCE RECLASS	I	ADMINISTRATIVE & GENERAL	6			25,470	11
23 CAFETERIA EXPENSE RECLASS	J	DIETARY	11		94,596	115,210	
24 HHA EXPENSE RECLASS	K	HOME HEALTH AGENCY	71			1,152	
25							
26 PPO ADMINISTRATIVE RECLASS	L	DURABLE MEDICAL EQUIP-RENTED	66			31	
27 ONCOLOGY PHARMACY COST RECLASS	M	CLINIC	60			4,148	
28 INTEREST EXPENSE RECLASS	N	INTEREST EXPENSE	88			300,941	11
29 REAL ESTATE TAX RECLASS	O	ADMINISTRATIVE & GENERAL	6			12,402	13
30 TO RECLASS MEDICAL SUPPLY EXPENSE	P	RESPIRATORY THERAPY	49			26,204	
36 TOTAL RECLASSIFICATIONS					157,468	1,365,038	

(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:	PERIOD:	PREPARED 11/ 6/2008
140019	FROM 9/ 1/2007	WORKSHEET A-6
	TO 8/31/2008	NOT A CMS WORKSHEET

RECLASS CODE: A
EXPLANATION : MEDICAL CENTER RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	19,388	HOUSEKEEPING	10	19,388	
TOTAL RECLASSIFICATIONS FOR CODE A			19,388				

RECLASS CODE: B
EXPLANATION : FIRE INSURANCE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	OTHER CAPITAL RELATED COSTS	90	16,925	ADMINISTRATIVE & GENERAL	6	18,283	
2.00	PHYSICIANS' PRIVATE OFFICES	98	1,358			0	
TOTAL RECLASSIFICATIONS FOR CODE B			18,283	18,283			

RECLASS CODE: C
EXPLANATION : TELEPHONE EXPENSE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	20,583	CENTRAL SERVICES & SUPPLY	15	7,763	
2.00			0	DRUGS CHARGED TO PATIENTS	56	423	
3.00			0	CLINIC	60	748	
4.00			0	RURAL HEALTH CLINIC	63.50	4,542	
5.00			0	DURABLE MEDICAL EQUIP-RENTED	66	3,072	
6.00			0	HOME HEALTH AGENCY	71	4,035	
TOTAL RECLASSIFICATIONS FOR CODE C			20,583	20,583			

RECLASS CODE: D
EXPLANATION : EMPLOYEE BENEFIT EXPENSE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	EMPLOYEE BENEFITS	5	175,164	ADMINISTRATIVE & GENERAL	6	175,164	
TOTAL RECLASSIFICATIONS FOR CODE D			175,164	175,164			

RECLASS CODE: E
EXPLANATION : RENTAL EXPENSE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	23,483	ADMINISTRATIVE & GENERAL	6	8,091	
2.00	RADIOLOGY-DIAGNOSTIC	41	5,400	MAINTENANCE & REPAIRS	7	2,675	
3.00			0	CAFETERIA	12	28	
4.00			0	CENTRAL SERVICES & SUPPLY	15	334	
5.00			0	SKILLED NURSING FACILITY	34	362	
6.00			0	OPERATING ROOM	37	12,360	
7.00			0	DURABLE MEDICAL EQUIP-RENTED	66	5,033	
TOTAL RECLASSIFICATIONS FOR CODE E			28,883	28,883			

RECLASS CODE: F
EXPLANATION : MEDICAL CENTER UTILITIES RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	17,600	OPERATION OF PLANT	8	17,600	
TOTAL RECLASSIFICATIONS FOR CODE F			17,600	17,600			

RECLASS CODE: G
EXPLANATION : PHYSICIAN BUILDING DEPRECIATION REC

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	PHYSICIANS' PRIVATE OFFICES	98	11,704	NEW CAP REL COSTS-BLDG & FIXT	3	10,018	
2.00			0	NEW CAP REL COSTS-MVBLE EQUIP	4	1,686	
TOTAL RECLASSIFICATIONS FOR CODE G			11,704	11,704			

RECLASS CODE: H
EXPLANATION : DEPRECIATION EXPENSE RECLASS

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	650,747	NEW CAP REL COSTS-BLDG & FIXT	3	650,747	
TOTAL RECLASSIFICATIONS FOR CODE H			650,747	650,747			

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
140019	FROM 9/ 1/2007	11/ 6/2008
	TO 8/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: I
EXPLANATION : PROPERTY INSURANCE RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	25,470
TOTAL RECLASSIFICATIONS FOR CODE I			25,470

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	25,470	
			25,470

RECLASS CODE: J
EXPLANATION : CAFETERIA EXPENSE RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	209,806
TOTAL RECLASSIFICATIONS FOR CODE J			209,806

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DIETARY	11	209,806	
			209,806

RECLASS CODE: K
EXPLANATION : HHA EXPENSE RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	576
2.00	RURAL HEALTH CLINIC	63.50	576
TOTAL RECLASSIFICATIONS FOR CODE K			1,152

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
HOME HEALTH AGENCY	71	1,152	
			0
			1,152

RECLASS CODE: L
EXPLANATION : PPO ADMINISTRATIVE RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	31
TOTAL RECLASSIFICATIONS FOR CODE L			31

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
DURABLE MEDICAL EQUIP-RENTED	66	31	
			31

RECLASS CODE: M
EXPLANATION : ONCOLOGY PHARMACY COST RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	4,148
TOTAL RECLASSIFICATIONS FOR CODE M			4,148

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
CLINIC	60	4,148	
			4,148

RECLASS CODE: N
EXPLANATION : INTEREST EXPENSE RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	300,941
TOTAL RECLASSIFICATIONS FOR CODE N			300,941

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
INTEREST EXPENSE	88	300,941	
			300,941

RECLASS CODE: O
EXPLANATION : REAL ESTATE TAX RECLASS

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	90	12,402
TOTAL RECLASSIFICATIONS FOR CODE O			12,402

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
ADMINISTRATIVE & GENERAL	6	12,402	
			12,402

RECLASS CODE: P
EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

----- INCREASE -----			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	26,204
TOTAL RECLASSIFICATIONS FOR CODE P			26,204

----- DECREASE -----			
COST CENTER	LINE	AMOUNT	
RESPIRATORY THERAPY	49	26,204	
			26,204

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
		BALANCES 1	PURCHASES 2	DONATION 3				
1	LAND	784,709					784,709	
2	LAND IMPROVEMENTS	245,904					245,904	
3	BUILDINGS & FIXTURE	10,765,415	7,284		7,284	3,000	10,769,699	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	3,536,814	155,447		155,447	2,934	3,689,327	
6	MOVABLE EQUIPMENT	7,360,808	321,788		321,788		7,682,596	
7	SUBTOTAL	22,693,650	484,519		484,519	5,934	23,172,235	
8	RECONCILING ITEMS							
9	TOTAL	22,693,650	484,519		484,519	5,934	23,172,235	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	COMPUTATION OF RATIOS CAPITLIZED GROSS ASSETS			ALLOCATION OF OTHER CAPITAL			TOTAL 8
			LEASES 2	FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	
3	NEW CAP REL COSTS-BL	15,492,639		15,492,639	.668500	28,341	8,291	36,632	
4	NEW CAP REL COSTS-MV	7,682,596		7,682,596	.331500	14,054	4,111	18,165	
5	TOTAL	23,175,235		23,175,235	1.000000	42,395	12,402	54,797	

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	506,890			28,341	8,291	543,522	
4	NEW CAP REL COSTS-MV	649,061	23,483		14,054	4,111	690,709	
5	TOTAL	1,155,951	23,483		42,395	12,402	1,234,231	

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

*	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	
3	NEW CAP REL COSTS-BL	1,168,505					1,168,505	
4	NEW CAP REL COSTS-MV							
5	TOTAL	1,168,505					1,168,505	

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:
I 14-0019
I

I PERIOD: I PREPARED 11/ 6/2008
I FROM 9/ 1/2007 I WORKSHEET A-8
I TO 8/31/2008 I

DESCRIPTION (1)	(2) BASIS/CODE	AMOUNT	EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
			WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE NO	
	1	2	COST CENTER 3	4	
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3 INVST INCOME-NEW BLDGS AND FIXTURES	A	-300,941	NEW CAP REL COSTS-BLDG &	3	11
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-523,653			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-48,197	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-11,298	MEDICAL RECORDS & LIBRARY	17	
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22 VENDING MACHINES					
23 INCOME FROM IMPOSITION OF INTEREST					
24 INTRST EXP ON MEDICARE OVERPAYMENTS					
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28 UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33 NON-PHYSICIAN ANESTHETIST	A	-35,336	NONPHYSICIAN ANESTHETISTS	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 LIFELINE INCOME	A	-29,121	HOME HEALTH AGENCY	71	
38 DEPRECIATION EXPENSE	A	-850	NEW CAP REL COSTS-BLDG &	3	9
39 MISCELLANEOUS INCOME	B	-2,403	ADMINISTRATIVE & GENERAL	6	
40 SICK BAY INCOME	B	-38	ADULTS & PEDIATRICS	25	
41 NURSING SERVICES SOLD - HOSPITAL	B	-26,156	HOME HEALTH AGENCY	71	
42 SUPPLIES SOLD - HOSPITAL	B	-2,347	MEDICAL SUPPLIES CHARGED	55	
43 COMMUNITY EDUCATION	B	-7,950	ADMINISTRATIVE & GENERAL	6	
44 INSURANCE EXPENSE	A	-1,076,116	EMPLOYEE BENEFITS	5	
45 ADVERTISING	A	-700	ADMINISTRATIVE & GENERAL	6	
46 SWITCHBOARD SALARY EXPENSE	A	-563	ADMINISTRATIVE & GENERAL	6	
47 SWITCHBOARD BENEFIT EXPENSE	A	-172	EMPLOYEE BENEFITS	5	
48 PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	6	
49 LOBBYING DUES	A	-11,047	ADMINISTRATIVE & GENERAL	6	
49.01 FOUNDATION EXPENSE	A	-109,945	ADMINISTRATIVE & GENERAL	6	
49.02 DR. LEVIN'S BENEFIT EXPENSE	A	-259	EMPLOYEE BENEFITS	5	
49.03 BAD DEBT EXPENSE	A	-3,163	DURABLE MEDICAL EQUIP-REN	66	
49.04 SURETY BOND	A	-50	ADMINISTRATIVE & GENERAL	6	
49.05 NONALLOWABLE BEVERAGES	A	-186	ADMINISTRATIVE & GENERAL	6	
50 TOTAL (SUM OF LINES 1 THRU 49)		-2,194,196			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET A-8-2
 I I TO 8/31/2008 I GROUP 1

1	2	3	4	5	6	7	8	9
WKSHT A	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
LINE NO.	1	2	3	4	5	6	7	8
34	SNF MEDICAL DIRECTOR	2,480	1,280	1,200	159,800	30	2,305	115
49	RESPIRATORY THERPAY	61,825	61,825					
60	CLINIC	846	846					
61	EMERGENCY	764,090	416,276	347,814	159,800	3,962	304,388	15,219
101	TOTAL	829,241	480,227	349,014		3,992	306,693	15,334

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO:
I 14-0019
I

I PERIOD:
I FROM 9/ 1/2007
I TO 8/31/2008

I PREPARED 11/ 6/2008
I WORKSHEET A-8-2
I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1 34	SNF MEDICAL DIRECTOR							
2 49	RESPIRATORY THERPAY					2,305		1,280
3 60	CLINIC							61,825
4 61	EMERGENCY							846
5						304,388	43,426	459,702
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					306,693	43,426	523,653

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I NOT A CMS WORKSHEET
 I I TO 8/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	3	SQUARE	FEET	ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MAN	HOURS	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
20	NONPHYSICIAN ANESTHETISTS	18	ASSIGNED	TIME	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B
 I I TO 8/31/2008 I PART I

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL OSTS-BLDG &	NEW CAP REL OSTS-MVBLE	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	5	5a.00	6	7
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &	543,522	543,522					
005	NEW CAP REL COSTS-MVBLE E	690,709		690,709				
006	EMPLOYEE BENEFITS	789,213	7,088	9,007	805,308			
007	ADMINISTRATIVE & GENERAL	1,668,696	68,262	86,747	117,027	1,940,732	1,940,732	
008	MAINTENANCE & REPAIRS	325,932	11,594	14,734	32,795	385,055	71,637	456,692
009	OPERATION OF PLANT	330,291	14,503	18,431		363,225	67,576	14,507
010	LAUNDRY & LINEN SERVICE	42,607	12,670	16,102	2,580	73,959	13,760	12,674
011	HOUSEKEEPING	216,743	5,087	6,464	29,358	257,652	47,935	5,088
012	DIETARY	256,484	15,756	20,023	16,982	309,245	57,533	15,760
013	CAFETERIA	161,581	6,020	7,650	13,892	189,143	35,189	6,021
014	NURSING ADMINISTRATION	322,961	5,784	7,351	45,885	381,981	71,065	5,786
015	CENTRAL SERVICES & SUPPLY	101,745	32,891	41,798	13,163	189,597	35,273	32,899
016	MEDICAL RECORDS & LIBRARY	220,459	9,980	12,682	29,200	272,321	50,664	9,982
017	NONPHYSICIAN ANESTHETISTS							
018	INPAT ROUTINE SRVC CNTRS							
019	ADULTS & PEDIATRICS	1,005,023	90,551	115,070	108,463	1,319,107	245,407	90,574
020	SKILLED NURSING FACILITY	474,786	25,618	32,556	59,021	591,981	110,135	25,625
021	ANCILLARY SRVC COST CNTRS							
022	OPERATING ROOM	128,106	51,362	65,272	11,929	256,669	47,752	51,375
023	ANESTHESIOLOGY	1,284	1,009	1,282		3,575	665	1,009
024	RADIOLOGY-DIAGNOSTIC	893,241	44,384	56,403	39,549	1,033,577	192,291	44,395
025	LABORATORY	961,896	17,547	22,299	63,259	1,065,001	198,137	17,551
026	RESPIRATORY THERAPY	175,530	12,376	15,728	24,019	227,653	42,353	12,379
027	PHYSICAL THERAPY	263,509	32,412	41,189	32,405	369,515	68,746	32,420
028	01 CARDIAC REHAB	25,101	12,006	15,257	3,502	55,866	10,394	12,009
029	MEDICAL SUPPLIES CHARGED	44,756	252	321		45,329	8,433	252
030	DRUGS CHARGED TO PATIENTS	1,065,830	6,390	8,120		1,080,340	200,991	6,391
031	OUTPAT SERVICE COST CNTRS							
032	CLINIC	124,471	17,606	22,373	16,573	181,023	33,678	17,610
033	EMERGENCY	619,838	12,914	16,411	39,461	688,624	128,114	12,917
034	OBSERVATION BEDS (NON-DIS							
035	OTHER OUTPATIENT SERVICE							
036	50 RURAL HEALTH CLINIC	407,995	22,734	28,891	56,418	516,038	96,006	22,740
037	OTHER REIMBURS COST CNTRS							
038	DURABLE MEDICAL EQUIP-REN	200,450			11,154	211,604	39,368	
039	HOME HEALTH AGENCY	247,632	6,726	8,548	35,826	298,732	55,577	6,728
040	SPEC PURPOSE COST CENTERS							
041	SUBTOTALS	12,310,391	543,522	690,709	802,461	12,307,544	1,928,679	456,692
042	NONREIMBURS COST CENTERS							
043	GIFT, FLOWER, COFFEE SHOP							
044	PHYSICIANS' PRIVATE OFFIC	51,177			2,847	54,024	10,051	
045	OTHER NONREIMBURSABLE COS							
046	01 FARM EXPENSE	10,763				10,763	2,002	
047	02 UNOCCUPIED SPACE							
048	CROSS FOOT ADJUSTMENT							
049	NEGATIVE COST CENTER							
050	TOTAL	12,372,331	543,522	690,709	805,308	12,372,331	1,940,732	456,692

COST ALLOCATION - GENERAL SERVICE COSTS

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PROVIDER NO:
14-0019

PERIOD:
FROM 9/ 1/2007
TO 8/31/2008

PREPARED 11/ 6/2008
WORKSHEET B
PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
	8	9	10	11	12	14	15
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	445,308						
010 LAUNDRY & LINEN SERVICE	12,763	113,156					
011 HOUSEKEEPING	5,124		315,799				
012 DIETARY	15,871		11,726	410,135			
014 CAFETERIA	6,064		4,480	184,539	425,436		
015 NURSING ADMINISTRATION	5,827		4,305		18,904	487,868	
017 CENTRAL SERVICES & SUPPLY	33,131	1,894	24,479		9,411	3,490	330,174
020 MEDICAL RECORDS & LIBRARY	10,053		7,428		26,175		6,856
025 NONPHYSICIAN ANESTHETISTS							
034 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	91,211	53,429	67,392	122,524	82,166	234,784	
040 SKILLED NURSING FACILITY	25,806	32,172	19,066	102,284	41,876	117,095	
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	51,738		38,227	788	5,206	15,920	
049 ANESTHESIOLOGY	1,016		751				
050 RADIOLOGY-DIAGNOSTIC	44,709	7,363	33,033		32,858		32,496
056 LABORATORY	17,675		13,059		35,924		252,787
060 RESPIRATORY THERAPY	12,467	265	9,211		26,005	23,479	16,309
063 PHYSICAL THERAPY	32,649	4,588	24,122		14,470		
066 01 CARDIAC REHAB	12,094		8,936		1,809	5,422	
071 MEDICAL SUPPLIES CHARGED	254		188				
075 DRUGS CHARGED TO PATIENTS	6,437		4,756				3,842
080 OUTPAT SERVICE COST CNTRS							
086 CLINIC	17,734		13,103		9,829	29,844	3,592
091 EMERGENCY	13,009	13,098	9,611		19,462	57,834	
096 OBSERVATION BEDS (NON-DIS							
098 OTHER OUTPATIENT SERVICE							
100 50 RURAL HEALTH CLINIC	22,901	187	16,920		25,134		10,863
101 OTHER REIMBURS COST CNTRS							
102 DURABLE MEDICAL EQUIP-REN					35,255		3,084
103 HOME HEALTH AGENCY	6,775		5,006		38,419		345
104 SPEC PURPOSE COST CENTERS							
105 SUBTOTALS	445,308	112,996	315,799	410,135	422,903	487,868	330,174
106 NONREIMBURS COST CENTERS							
107 GIFT, FLOWER, COFFEE SHOP							
108 PHYSICIANS' PRIVATE OFFIC		160			2,533		
109 OTHER NONREIMBURSABLE COS							
110 01 FARM EXPENSE							
111 02 UNOCCUPIED SPACE							
112 CROSS FOOT ADJUSTMENT							
113 NEGATIVE COST CENTER							
114 TOTAL	445,308	113,156	315,799	410,135	425,436	487,868	330,174

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B
 I I TO 8/31/2008 I PART I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	20	25	26	27
003 GENERAL SERVICE COST CNTR					
004 NEW CAP REL COSTS-BLDG &					
005 NEW CAP REL COSTS-MVBLE E					
006 EMPLOYEE BENEFITS					
007 ADMINISTRATIVE & GENERAL					
008 MAINTENANCE & REPAIRS					
009 OPERATION OF PLANT					
010 LAUNDRY & LINEN SERVICE					
011 HOUSEKEEPING					
012 DIETARY					
014 CAFETERIA					
014 NURSING ADMINISTRATION					
015 CENTRAL SERVICES & SUPPLY					
017 MEDICAL RECORDS & LIBRARY	383,479				
020 NONPHYSICIAN ANESTHETISTS					
025 INPAT ROUTINE SRVC CNTRS					
025 ADULTS & PEDIATRICS	194,547		2,501,141		2,501,141
034 SKILLED NURSING FACILITY	3,017		1,069,057		1,069,057
037 ANCILLARY SRVC COST CNTRS					
037 OPERATING ROOM	947		468,622		468,622
040 ANESTHESIOLOGY			7,016		7,016
041 RADIOLOGY-DIAGNOSTIC	98,659		1,519,381		1,519,381
044 LABORATORY	27,998		1,628,132		1,628,132
049 RESPIRATORY THERAPY			370,121		370,121
050 PHYSICAL THERAPY	9,438		555,948		555,948
050 01 CARDIAC REHAB			106,530		106,530
055 MEDICAL SUPPLIES CHARGED			54,456		54,456
056 DRUGS CHARGED TO PATIENTS			1,302,757		1,302,757
060 OUTPAT SERVICE COST CNTRS					
061 CLINIC			306,413		306,413
061 EMERGENCY	48,873		991,542		991,542
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			710,789		710,789
066 OTHER REIMBURS COST CNTRS					
066 DURABLE MEDICAL EQUIP-REN			289,311		289,311
071 HOME HEALTH AGENCY			411,582		411,582
095 SPEC PURPOSE COST CENTERS					
095 SUBTOTALS	383,479		12,292,798		12,292,798
096 NONREIMBURS COST CENTERS					
096 GIFT, FLOWER, COFFEE SHOP					
098 PHYSICIANS' PRIVATE OFFIC			66,768		66,768
100 OTHER NONREIMBURSABLE COS					
100 01 FARM EXPENSE			12,765		12,765
100 02 UNOCCUPIED SPACE					
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	383,479		12,372,331		12,372,331

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B
 I I TO 8/31/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	4a	5	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS		7,088	9,007	16,095	16,095		
006 ADMINISTRATIVE & GENERAL		68,262	86,747	155,009	2,338	157,347	
007 MAINTENANCE & REPAIRS		11,594	14,734	26,328	655	5,808	32,791
008 OPERATION OF PLANT		14,503	18,431	32,934		5,479	1,042
009 LAUNDRY & LINEN SERVICE		12,670	16,102	28,772	52	1,116	910
010 HOUSEKEEPING		5,087	6,464	11,551	587	3,886	365
011 DIETARY		15,756	20,023	35,779	339	4,665	1,132
012 CAFETERIA		6,020	7,650	13,670	278	2,853	432
014 NURSING ADMINISTRATION		5,784	7,351	13,135	917	5,762	415
015 CENTRAL SERVICES & SUPPLY		32,891	41,798	74,689	263	2,860	2,362
017 MEDICAL RECORDS & LIBRARY		9,980	12,682	22,662	584	4,108	717
020 NONPHYSICIAN ANESTHETISTS							
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS		90,551	115,070	205,621	2,168	19,893	6,504
034 SKILLED NURSING FACILITY		25,618	32,556	58,174	1,180	8,929	1,840
037 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		51,362	65,272	116,634	238	3,872	3,689
040 ANESTHESIOLOGY		1,009	1,282	2,291		54	72
041 RADIOLOGY-DIAGNOSTIC		44,384	56,403	100,787	790	15,590	3,188
044 LABORATORY		17,547	22,299	39,846	1,264	16,064	1,260
049 RESPIRATORY THERAPY		12,376	15,728	28,104	480	3,434	889
050 PHYSICAL THERAPY		32,412	41,189	73,601	648	5,574	2,328
050 01 CARDIAC REHAB		12,006	15,257	27,263	70	843	862
055 MEDICAL SUPPLIES CHARGED		252	321	573		684	18
056 DRUGS CHARGED TO PATIENTS		6,390	8,120	14,510		16,296	459
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC		17,606	22,373	39,979	331	2,731	1,264
061 EMERGENCY		12,914	16,411	29,325	789	10,387	927
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		22,734	28,891	51,625	1,128	7,784	1,633
066 OTHER REIMBURS COST CNTRS							
066 DURABLE MEDICAL EQUIP-REN					223	3,192	
071 HOME HEALTH AGENCY		6,726	8,548	15,274	716	4,506	483
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		543,522	690,709	1,234,231	16,038	156,370	32,791
096 NONREIMBURS COST CENTERS							
096 GIFT, FLOWER, COFFEE SHOP							
098 PHYSICIANS' PRIVATE OFFIC					57	815	
100 OTHER NONREIMBURSABLE COS							
100 01 FARM EXPENSE						162	
100 02 UNOCCUPIED SPACE							
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		543,522	690,709	1,234,231	16,095	157,347	32,791

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B
 I TO 8/31/2008 I PART III

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
		8	9	10	11	12	14	15
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT	39,455						
010	LAUNDRY & LINEN SERVICE	1,131	31,981					
011	HOUSEKEEPING	454		16,843				
012	DIETARY	1,406		625	43,946			
013	CAFETERIA	537		239	19,774	37,783		
014	NURSING ADMINISTRATION	516		230		1,679	22,654	
015	CENTRAL SERVICES & SUPPLY	2,935	535	1,306		836		85,948
017	MEDICAL RECORDS & LIBRARY	891		396		2,325		1,785
020	NONPHYSICIAN ANESTHETISTS							
025	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	8,082	15,100	3,592	13,128	7,297	10,902	
034	SKILLED NURSING FACILITY	2,286	9,093	1,017	10,960	3,719	5,437	
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	4,584		2,039	84	462	739	
040	ANESTHESIOLOGY	90		40				
041	RADIOLOGY-DIAGNOSTIC	3,961	2,081	1,762		2,918		8,459
044	LABORATORY	1,566		697		3,190		65,803
049	RESPIRATORY THERAPY	1,105	75	491		2,310	1,090	4,245
050	PHYSICAL THERAPY	2,893	1,297	1,287		1,285		
050	01 CARDIAC REHAB	1,072		477		161	252	
055	MEDICAL SUPPLIES CHARGED	23		10				
056	DRUGS CHARGED TO PATIENTS	570		254				1,000
	OUTPAT SERVICE COST CNTRS							
060	CLINIC	1,571		699		873	1,386	935
061	EMERGENCY	1,153	3,702	513		1,728	2,686	
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC	2,029	53	902		2,232		2,828
	OTHER REIMBURS COST CNTRS							
066	DURABLE MEDICAL EQUIP-REN					3,131		803
071	HOME HEALTH AGENCY	600		267		3,412		90
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	39,455	31,936	16,843	43,946	37,558	22,654	85,948
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
098	PHYSICIANS' PRIVATE OFFIC		45			225		
100	OTHER NONREIMBURSABLE COS							
100	01 FARM EXPENSE							
100	02 UNOCCUPIED SPACE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	39,455	31,981	16,843	43,946	37,783	22,654	85,948

ALLOCATION OF NEW CAPITAL RELATED COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET B
I		I	TO 8/31/2008	I	PART III

	COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	NONPHYSICIAN ANESTHETISTS	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	GENERAL SERVICE COST CNTR	17	20	25	26	27
003	NEW CAP REL COSTS-BLDG &					
004	NEW CAP REL COSTS-MVBLE E					
005	EMPLOYEE BENEFITS					
006	ADMINISTRATIVE & GENERAL					
007	MAINTENANCE & REPAIRS					
008	OPERATION OF PLANT					
009	LAUNDRY & LINEN SERVICE					
010	HOUSEKEEPING					
011	DIETARY					
012	CAFETERIA					
014	NURSING ADMINISTRATION					
015	CENTRAL SERVICES & SUPPLY					
017	MEDICAL RECORDS & LIBRARY	33,468				
020	NONPHYSICIAN ANESTHETISTS					
	INPAT ROUTINE SRVC CNTRS					
025	ADULTS & PEDIATRICS	16,979		309,266		309,266
034	SKILLED NURSING FACILITY	263		102,898		102,898
	ANCILLARY SRVC COST CNTRS					
037	OPERATING ROOM	83		132,424		132,424
040	ANESTHESIOLOGY			2,547		2,547
041	RADIOLOGY-DIAGNOSTIC	8,610		148,146		148,146
044	LABORATORY	2,444		132,134		132,134
049	RESPIRATORY THERAPY			42,223		42,223
050	PHYSICAL THERAPY	824		89,737		89,737
050	01 CARDIAC REHAB			31,000		31,000
055	MEDICAL SUPPLIES CHARGED			1,308		1,308
056	DRUGS CHARGED TO PATIENTS			33,089		33,089
	OUTPAT SERVICE COST CNTRS					
060	CLINIC			49,769		49,769
061	EMERGENCY	4,265		55,475		55,475
062	OBSERVATION BEDS (NON-DIS					
063	OTHER OUTPATIENT SERVICE					
063	50 RURAL HEALTH CLINIC			70,214		70,214
	OTHER REIMBURS COST CNTRS					
066	DURABLE MEDICAL EQUIP-REN			7,349		7,349
071	HOME HEALTH AGENCY			25,348		25,348
	SPEC PURPOSE COST CENTERS					
095	SUBTOTALS	33,468		1,232,927		1,232,927
	NONREIMBURS COST CENTERS					
096	GIFT, FLOWER, COFFEE SHOP					
098	PHYSICIANS' PRIVATE OFFIC			1,142		1,142
100	OTHER NONREIMBURSABLE COS					
100	01 FARM EXPENSE			162		162
100	02 UNOCCUPIED SPACE					
101	CROSS FOOT ADJUSTMENTS					
102	NEGATIVE COST CENTER					
103	TOTAL	33,468		1,234,231		1,234,231

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B-1
 I I TO 8/31/2008 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	OSTS-BLDG & FEET	OSTS-MVBLE E FEET	FITS SALARIES		ACCUM. COST	SQUARE FEET
	(3) 4	(5) 6a.00	(6) 7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	64,646					
005 NEW CAP REL COSTS-MVB		64,646				
006 EMPLOYEE BENEFITS	843	843	5,483,809			
007 ADMINISTRATIVE & GENE	8,119	8,119	796,912	-1,940,732	10,431,599	
008 MAINTENANCE & REPAIRS	1,379	1,379	223,317		385,055	54,305
009 OPERATION OF PLANT	1,725	1,725			363,225	1,725
010 LAUNDRY & LINEN SERVI	1,507	1,507	17,566		73,959	1,507
011 HOUSEKEEPING	605	605	199,918		257,652	605
012 DIETARY	1,874	1,874	115,641		309,245	1,874
014 CAFETERIA	716	716	94,596		189,143	716
015 NURSING ADMINISTRATIO	688	688	312,459		381,981	688
017 CENTRAL SERVICES & SU	3,912	3,912	89,633		189,597	3,912
020 MEDICAL RECORDS & LIB	1,187	1,187	198,839		272,321	1,187
025 NONPHYSICIAN ANESTHET						
034 INPAT ROUTINE SRVC CN	10,770	10,770	738,586		1,319,107	10,770
037 ADULTS & PEDIATRICS	3,047	3,047	401,908		591,981	3,047
040 SKILLED NURSING FACIL						
041 ANCILLARY SRVC COST C	6,109	6,109	81,231		256,669	6,109
044 OPERATING ROOM	120	120			3,575	120
049 ANESTHESIOLOGY	5,279	5,279	269,313		1,033,577	5,279
050 RADIOLOGY-DIAGNOSTIC	2,087	2,087	430,764		1,065,001	2,087
055 LABORATORY	1,472	1,472	163,562		227,653	1,472
056 RESPIRATORY THERAPY	3,855	3,855	220,662		369,515	3,855
051 PHYSICAL THERAPY	1,428	1,428	23,850		55,866	1,428
052 CARDIAC REHAB	30	30			45,329	30
053 MEDICAL SUPPLIES CHAR	760	760			1,080,340	760
060 DRUGS CHARGED TO PATI						
061 OUTPAT SERVICE COST C	2,094	2,094	112,856		181,023	2,094
062 CLINIC	1,536	1,536	268,711		688,624	1,536
063 EMERGENCY						
064 OBSERVATION BEDS (NON						
065 OTHER OUTPATIENT SERV						
066 RURAL HEALTH CLINIC	2,704	2,704	384,181		516,038	2,704
071 OTHER REIMBURS COST C						
075 DURABLE MEDICAL EQUIP			75,953		211,604	
095 HOME HEALTH AGENCY	800	800	243,963		298,732	800
098 SPEC PURPOSE COST CEN						
099 SUBTOTALS	64,646	64,646	5,464,421	-1,940,732	10,366,812	54,305
096 NONREIMBURS COST CENT						
097 GIFT, FLOWER, COFFEE						
098 PHYSICIANS' PRIVATE O			19,388		54,024	
100 OTHER NONREIMBURSABLE						
100 01 FARM EXPENSE					10,763	
100 02 UNOCCUPIED SPACE						
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	543,522	690,709	805,308		1,940,732	456,692
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	8.407666		.146852		.186044	8.409760
105 (WRKSHT B, PT I)		10.684482				
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER			16,095		157,347	32,791
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED						
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.002935		.015084	.603830
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO:
I 14-0019
I

I PERIOD:
I FROM 9/ 1/2007
I TO 8/31/2008

I PREPARED 11/ 6/2008
I WORKSHEET B-1
I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	(DIRECT NRSING HRS)	(COSTED REQUIS.)
	8	9	10	11	12	14	15
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD							
005 NEW CAP REL COSTS-MVB							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENE							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	52,580						
010 LAUNDRY & LINEN SERVI	1,507	166,690					
011 HOUSEKEEPING	605		50,468				
012 DIETARY	1,874		1,874	60,407			
014 CAFETERIA	716		716	27,180	286,193		
015 NURSING ADMINISTRATIO	688		688		12,717	107,073	
017 CENTRAL SERVICES & SU	3,912	2,790	3,912		6,331	766	530,490
020 MEDICAL RECORDS & LIB	1,187		1,187		17,608		11,015
025 NONPHYSICIAN ANESTHET							
034 INPAT ROUTINE SRVC CN	10,770	78,709	10,770	18,046	55,273	51,528	
037 ADULTS & PEDIATRICS	3,047	47,392	3,047	15,065	28,170	25,699	
040 SKILLED NURSING FACIL							
041 ANCILLARY SRVC COST C	6,109		6,109	116	3,502	3,494	
044 OPERATING ROOM	120		120				
049 ANESTHESIOLOGY	5,279	10,846	5,279		22,104		52,211
050 RADIOLOGY-DIAGNOSTIC	2,087		2,087		24,166		406,152
055 LABORATORY	1,472	390	1,472		17,494	5,153	26,204
056 RESPIRATORY THERAPY	3,855	6,758	3,855		9,734		
060 PHYSICAL THERAPY	1,428		1,428		1,217	1,190	
066 01 CARDIAC REHAB	30		30				
071 MEDICAL SUPPLIES CHAR	760		760				6,173
095 DRUGS CHARGED TO PATI							
096 OUTPAT SERVICE COST C	2,094		2,094		6,612	6,550	5,772
098 CLINIC	1,536	19,295	1,536		13,092	12,693	
100 EMERGENCY							
101 OBSERVATION BEDS (NON							
102 OTHER OUTPATIENT SERV	2,704	275	2,704		16,908		17,453
103 50 RURAL HEALTH CLINIC							
104 OTHER REIMBURS COST C							
105 DURABLE MEDICAL EQUIP	800		800		23,716		4,955
106 HOME HEALTH AGENCY					25,845		555
107 SPEC PURPOSE COST CEN							
108 SUBTOTALS	52,580	166,455	50,468	60,407	284,489	107,073	530,490
096 NONREIMBURS COST CENT							
098 GIFT, FLOWER, COFFEE		235			1,704		
100 PHYSICIANS' PRIVATE O							
101 OTHER NONREIMBURSABLE							
102 01 FARM EXPENSE							
103 02 UNOCCUPIED SPACE							
104 CROSS FOOT ADJUSTMENT							
105 NEGATIVE COST CENTER							
106 COST TO BE ALLOCATED	445,308	113,156	315,799	410,135	425,436	487,868	330,174
107 (WRKSHT B, PART I)							
108 UNIT COST MULTIPLIER		.678841		6.789528		4.556405	.622394
104 (WRKSHT B, PT I)	8.469152		6.257411		1.486535		
105 COST TO BE ALLOCATED							
106 (WRKSHT B, PART II)							
107 UNIT COST MULTIPLIER							
108 (WRKSHT B, PT II)							
104 COST TO BE ALLOCATED	39,455	31,981	16,843	43,946	37,783	22,654	85,948
105 (WRKSHT B, PART III)							
106 UNIT COST MULTIPLIER		.191859		.727498		.211575	
108 (WRKSHT B, PT III)	.750380		.333736		.132019		.162016

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET B-1
 I I TO 8/31/2008 I

	COST CENTER DESCRIPTION	MEDICAL RECOR NONPHYSICIAN DS & LIBRARY ANESTHETISTS	
		(TIME SPENT)	(ASSIGNED TIME)
		17	20
003	GENERAL SERVICE COST		
004	NEW CAP REL COSTS-BLD		
005	NEW CAP REL COSTS-MVB		
006	EMPLOYEE BENEFITS		
007	ADMINISTRATIVE & GENE		
008	MAINTENANCE & REPAIRS		
009	OPERATION OF PLANT		
010	LAUNDRY & LINEN SERVI		
011	HOUSEKEEPING		
012	DIETARY		
014	CAFETERIA		
015	NURSING ADMINISTRATIO		
017	CENTRAL SERVICES & SU	10,930	
020	MEDICAL RECORDS & LIB		336
025	NONPHYSICIAN ANESTHET		
034	INPAT ROUTINE SRVC CN	5,545	
037	ADULTS & PEDIATRICS	86	
040	SKILLED NURSING FACIL	27	
041	ANCILLARY SRVC COST C		336
044	OPERATING ROOM	2,812	
049	ANESTHESIOLOGY	798	
050	RADIOLOGY-DIAGNOSTIC	269	
055	LABORATORY		
056	RESPIRATORY THERAPY		
060	PHYSICAL THERAPY		
061	01 CARDIAC REHAB		
062	MEDICAL SUPPLIES CHAR		
063	DRUGS CHARGED TO PATI		
066	OUTPAT SERVICE COST C		
071	CLINIC		
095	EMERGENCY	1,393	
096	OBSERVATION BEDS (NON		
098	OTHER OUTPATIENT SERV		
100	50 RURAL HEALTH CLINIC		
101	OTHER REIMBURS COST C		
102	DURABLE MEDICAL EQUIP		
103	HOME HEALTH AGENCY		
104	SPEC PURPOSE COST CEN		
105	01 SUBTOTALS	10,930	336
106	NONREIMBURS COST CENT		
107	GIFT, FLOWER, COFFEE		
108	PHYSICIANS' PRIVATE O		
109	OTHER NONREIMBURSABLE		
110	02 FARM EXPENSE		
111	UNOCCUPIED SPACE		
112	CROSS FOOT ADJUSTMENT		
113	NEGATIVE COST CENTER		
114	103 COST TO BE ALLOCATED	383,479	
115	(PER WRKSHT B, PART		
116	UNIT COST MULTIPLIER		
117	(WRKSHT B, PT I)	35.084995	
118	105 COST TO BE ALLOCATED		
119	(PER WRKSHT B, PART		
120	UNIT COST MULTIPLIER		
121	(WRKSHT B, PT II)	33,468	
122	107 COST TO BE ALLOCATED		
123	(PER WRKSHT B, PART		
124	UNIT COST MULTIPLIER		
125	(WRKSHT B, PT III)	3.062031	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET C
 I I TO 8/31/2008 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	2,501,141		2,501,141		2,501,141
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	1,069,057		1,069,057		1,069,057
37	OPERATING ROOM	468,622		468,622		468,622
40	ANESTHESIOLOGY	7,016		7,016		7,016
41	RADIOLOGY-DIAGNOSTIC	1,519,381		1,519,381		1,519,381
44	LABORATORY	1,628,132		1,628,132		1,628,132
49	RESPIRATORY THERAPY	370,121		370,121		370,121
50	PHYSICAL THERAPY	555,948		555,948		555,948
50	01 CARDIAC REHAB	106,530		106,530		106,530
55	MEDICAL SUPPLIES CHARGED	54,456		54,456		54,456
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	1,302,757		1,302,757		1,302,757
60	CLINIC	306,413		306,413		306,413
61	EMERGENCY	991,542		991,542	43,426	1,034,968
62	OBSERVATION BEDS (NON-DIS)	123,138		123,138		123,138
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	710,789		710,789		710,789
66	OTHER REIMBURS COST CNTRS DURABLE MEDICAL EQUIP-REN	289,311		289,311		289,311
101	SUBTOTAL	12,004,354		12,004,354	43,426	12,047,780
102	LESS OBSERVATION BEDS	123,138		123,138		123,138
103	TOTAL	11,881,216		11,881,216	43,426	11,924,642

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET C
 I I TO 8/31/2008 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						
	ADULTS & PEDIATRICS	4,474,311		4,474,311			
34	SKILLED NURSING FACILITY	630,867		630,867			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	10,786	480,181	490,967	.954488	.954488	.954488
40	ANESTHESIOLOGY	3,467	123,309	126,776	.055342	.055342	.055342
41	RADIOLOGY-DIAGNOSTIC	1,281,960	5,134,964	6,416,924	.236777	.236777	.236777
44	LABORATORY	1,738,105	4,115,380	5,853,485	.278147	.278147	.278147
49	RESPIRATORY THERAPY	584,222	807,516	1,391,738	.265942	.265942	.265942
50	PHYSICAL THERAPY	178,077	799,791	977,868	.568531	.568531	.568531
50	01 CARDIAC REHAB	97	93,705	93,802	1.135690	1.135690	1.135690
55	MEDICAL SUPPLIES CHARGED	646,728	89,277	736,005	.073989	.073989	.073989
56	DRUGS CHARGED TO PATIENTS	1,325,886	838,956	2,164,842	.601779	.601779	.601779
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	5,531	275,466	280,997	1.090449	1.090449	1.090449
61	EMERGENCY	232,913	1,165,128	1,398,041	.709237	.709237	.740299
62	OBSERVATION BEDS (NON-DIS	49,223	115,765	164,988	.746345	.746345	.746345
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		493,425	493,425	1.440521	1.440521	1.440521
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN		360,412	360,412	.802723	.802723	.802723
101	SUBTOTAL	11,162,173	14,893,275	26,055,448			
102	LESS OBSERVATION BEDS						
103	TOTAL	11,162,173	14,893,275	26,055,448			

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	2,501,141		2,501,141		2,501,141
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	1,069,057		1,069,057		1,069,057
37	OPERATING ROOM	468,622		468,622		468,622
40	ANESTHESIOLOGY	7,016		7,016		7,016
41	RADIOLOGY-DIAGNOSTIC	1,519,381		1,519,381		1,519,381
44	LABORATORY	1,628,132		1,628,132		1,628,132
49	RESPIRATORY THERAPY	370,121		370,121		370,121
50	PHYSICAL THERAPY	555,948		555,948		555,948
50	01 CARDIAC REHAB	106,530		106,530		106,530
55	MEDICAL SUPPLIES CHARGED	54,456		54,456		54,456
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	1,302,757		1,302,757		1,302,757
60	CLINIC	306,413		306,413		306,413
61	EMERGENCY	991,542		991,542	43,426	1,034,968
62	OBSERVATION BEDS (NON-DIS)	123,138		123,138		123,138
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	710,789		710,789		710,789
66	OTHER REIMBURS COST CNTRS DURABLE MEDICAL EQUIP-REN	289,311		289,311		289,311
101	SUBTOTAL	12,004,354		12,004,354	43,426	12,047,780
102	LESS OBSERVATION BEDS	123,138		123,138		123,138
103	TOTAL	11,881,216		11,881,216	43,426	11,924,642

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET C
I I TO 8/31/2008 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						
	ADULTS & PEDIATRICS	4,474,311		4,474,311			
34	SKILLED NURSING FACILITY	630,867		630,867			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	10,786	480,181	490,967	.954488	.954488	.954488
40	ANESTHESIOLOGY	3,467	123,309	126,776	.055342	.055342	.055342
41	RADIOLOGY-DIAGNOSTIC	1,281,960	5,134,964	6,416,924	.236777	.236777	.236777
44	LABORATORY	1,738,105	4,115,380	5,853,485	.278147	.278147	.278147
49	RESPIRATORY THERAPY	584,222	807,516	1,391,738	.265942	.265942	.265942
50	PHYSICAL THERAPY	178,077	799,791	977,868	.568531	.568531	.568531
50	01 CARDIAC REHAB	97	93,705	93,802	1.135690	1.135690	1.135690
55	MEDICAL SUPPLIES CHARGED	646,728	89,277	736,005	.073989	.073989	.073989
56	DRUGS CHARGED TO PATIENTS	1,325,886	838,956	2,164,842	.601779	.601779	.601779
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	5,531	275,466	280,997	1.090449	1.090449	1.090449
61	EMERGENCY	232,913	1,165,128	1,398,041	.709237	.709237	.740299
62	OBSERVATION BEDS (NON-DIS	49,223	115,765	164,988	.746345	.746345	.746345
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		493,425	493,425	1.440521	1.440521	1.440521
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN		360,412	360,412	.802723	.802723	.802723
101	SUBTOTAL	11,162,173	14,893,275	26,055,448			
102	LESS OBSERVATION BEDS						
103	TOTAL	11,162,173	14,893,275	26,055,448			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST	CAPITAL COST	OPERATING	CAPITAL	OPERATING COST	COST NET OF
		WKST B, PT I COL. 27 1	WKST B PT II & III, COL. 27 2	COST NET OF CAPITAL COST 3	REDUCTION 4	REDUCTION AMOUNT 5	CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	468,622	132,424	336,198			468,622
40	ANESTHESIOLOGY	7,016	2,547	4,469			7,016
41	RADIOLOGY-DIAGNOSTIC	1,519,381	148,146	1,371,235			1,519,381
44	LABORATORY	1,628,132	132,134	1,495,998			1,628,132
49	RESPIRATORY THERAPY	370,121	42,223	327,898			370,121
50	PHYSICAL THERAPY	555,948	89,737	466,211			555,948
50 01	CARDIAC REHAB	106,530	31,000	75,530			106,530
55	MEDICAL SUPPLIES CHARGED	54,456	1,308	53,148			54,456
56	DRUGS CHARGED TO PATIENTS	1,302,757	33,089	1,269,668			1,302,757
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	306,413	49,769	256,644			306,413
61	EMERGENCY	991,542	55,475	936,067			991,542
62	OBSERVATION BEDS (NON-DIS	123,138	17,484	105,654			123,138
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	710,789	70,214	640,575			710,789
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN	289,311	7,349	281,962			289,311
101	SUBTOTAL	8,434,156	812,899	7,621,257			8,434,156
102	LESS OBSERVATION BEDS	123,138	17,484	105,654			123,138
103	TOTAL	8,311,018	795,415	7,515,603			8,311,018

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
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	490,967	.954488	.954488
40	ANESTHESIOLOGY	126,776	.055342	.055342
41	RADIOLOGY-DIAGNOSTIC	6,416,924	.236777	.236777
44	LABORATORY	5,853,485	.278147	.278147
49	RESPIRATORY THERAPY	1,391,738	.265942	.265942
50	PHYSICAL THERAPY	977,868	.568531	.568531
50 01	CARDIAC REHAB	93,802	1.135690	1.135690
55	MEDICAL SUPPLIES CHARGED	736,005	.073989	.073989
56	DRUGS CHARGED TO PATIENTS	2,164,842	.601779	.601779
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	280,997	1.090449	1.090449
61	EMERGENCY	1,398,041	.709237	.709237
62	OBSERVATION BEDS (NON-DIS	164,988	.746345	.746345
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	493,425	1.440521	1.440521
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	360,412	.802723	.802723
101	SUBTOTAL	20,950,270		
102	LESS OBSERVATION BEDS	164,988		
103	TOTAL	20,785,282		

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	468,622	132,424	336,198			468,622
40	ANESTHESIOLOGY	7,016	2,547	4,469			7,016
41	RADIOLOGY-DIAGNOSTIC	1,519,381	148,146	1,371,235			1,519,381
44	LABORATORY	1,628,132	132,134	1,495,998			1,628,132
49	RESPIRATORY THERAPY	370,121	42,223	327,898			370,121
50	PHYSICAL THERAPY	555,948	89,737	466,211			555,948
50 01	CARDIAC REHAB	106,530	31,000	75,530			106,530
55	MEDICAL SUPPLIES CHARGED	54,456	1,308	53,148			54,456
56	DRUGS CHARGED TO PATIENTS	1,302,757	33,089	1,269,668			1,302,757
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	306,413	49,769	256,644			306,413
61	EMERGENCY	991,542	55,475	936,067			991,542
62	OBSERVATION BEDS (NON-DIS	123,138	17,484	105,654			123,138
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	710,789	70,214	640,575			710,789
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN	289,311	7,349	281,962			289,311
101	SUBTOTAL	8,434,156	812,899	7,621,257			8,434,156
102	LESS OBSERVATION BEDS	123,138	17,484	105,654			123,138
103	TOTAL	8,311,018	795,415	7,515,603			8,311,018

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
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	490,967	.954488	.954488
40	ANESTHESIOLOGY	126,776	.055342	.055342
41	RADIOLOGY-DIAGNOSTIC	6,416,924	.236777	.236777
44	LABORATORY	5,853,485	.278147	.278147
49	RESPIRATORY THERAPY	1,391,738	.265942	.265942
50	PHYSICAL THERAPY	977,868	.568531	.568531
50 01	CARDIAC REHAB	93,802	1.135690	1.135690
55	MEDICAL SUPPLIES CHARGED	736,005	.073989	.073989
56	DRUGS CHARGED TO PATIENTS	2,164,842	.601779	.601779
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	280,997	1.090449	1.090449
61	EMERGENCY	1,398,041	.709237	.709237
62	OBSERVATION BEDS (NON-DIS	164,988	.746345	.746345
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	493,425	1.440521	1.440521
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-REN	360,412	.802723	.802723
101	SUBTOTAL	20,950,270		
102	LESS OBSERVATION BEDS	164,988		
103	TOTAL	20,785,282		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I I TO 8/31/2008 I PART I

TITLE XVIII, PART A

PPS

WKST A	COST CENTER DESCRIPTION	TOTAL	INPATIENT	OLD CAPITAL	INPAT PROGRAM	NEW CAPITAL	INPAT PROGRAM
LINE NO.		PATIENT DAYS	PROGRAM DAYS	PER DIEM	OLD CAP CST	PER DIEM	NEW CAP CST
		7	8	9	10	11	12
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	3,290	2,328			81.86	190,570
101	TOTAL	3,290	2,328				190,570

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 8/31/2008 I PART II
 I 14-0019 I I

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM		132,424	490,967	3,689		
40	ANESTHESIOLOGY		2,547	126,776	956		
41	RADIOLOGY-DIAGNOSTIC		148,146	6,416,924	1,102,743		
44	LABORATORY		132,134	5,853,485	1,391,998		
49	RESPIRATORY THERAPY		42,223	1,391,738	324,740		
50	PHYSICAL THERAPY		89,737	977,868	26,998		
50 01	CARDIAC REHAB		31,000	93,802			
55	MEDICAL SUPPLIES CHARGED		1,308	736,005	386,108		
56	DRUGS CHARGED TO PATIENTS		33,089	2,164,842	734,720		
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		49,769	280,997	505		
61	EMERGENCY		55,475	1,398,041	161,514		
62	OBSERVATION BEDS (NON-DIS		17,484	164,988	15,536		
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN		7,349	360,412			
101	TOTAL		742,685	20,456,845	4,149,507		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 8/31/2008 I PART II
 I 14-0019 I
 PPS

TITLE XVIII, PART A HOSPITAL

WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM	.269721	995
40	ANESTHESIOLOGY	.020091	19
41	RADIOLOGY-DIAGNOSTIC	.023087	25,459
44	LABORATORY	.022574	31,423
49	RESPIRATORY THERAPY	.030338	9,852
50	PHYSICAL THERAPY	.091768	2,478
50 01	CARDIAC REHAB	.330483	
55	MEDICAL SUPPLIES CHARGED	.001777	686
56	DRUGS CHARGED TO PATIENTS	.015285	11,230
	OUTPAT SERVICE COST CNTRS		
60	CLINIC	.177116	89
61	EMERGENCY	.039681	6,409
62	OBSERVATION BEDS (NON-DIS	.105971	1,646
63	OTHER OUTPATIENT SERVICE		
63 50	RURAL HEALTH CLINIC		
	OTHER REIMBURS COST CNTRS		
66	DURABLE MEDICAL EQUIP-REN	.020391	
101	TOTAL		90,286

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

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I I TO 8/31/2008 I PART III

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST	MED EDUCATN COST	SWING BED ADJ AMOUNT	TOTAL COSTS	TOTAL PATIENT DAYS	PER DIEM
		1	2	3	4	5	6
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS					3,290	
34	SKILLED NURSING FACILITY					5,004	
101	TOTAL					8,294	

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

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I I TO 8/31/2008 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT PROG DAYS	INPAT PROGRAM PASS THRU COST
25	ADULTS & PEDIATRICS	7	2,328
34	SKILLED NURSING FACILITY		573
101	TOTAL		2,901

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED SCHOOL	NRS COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2		2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM							
40	ANESTHESIOLOGY							
41	RADIOLOGY-DIAGNOSTIC							
44	LABORATORY							
49	RESPIRATORY THERAPY							
50	PHYSICAL THERAPY							
50 01	CARDIAC REHAB							
55	MEDICAL SUPPLIES CHARGED							
56	DRUGS CHARGED TO PATIENTS							
	OUTPAT SERVICE COST CNTRS							
60	CLINIC							
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS							
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
66	DURABLE MEDICAL EQUIP-REN							
101	TOTAL							

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			490,967			3,689	
40	ANESTHESIOLOGY			126,776			956	
41	RADIOLOGY-DIAGNOSTIC			6,416,924			1,102,743	
44	LABORATORY			5,853,485			1,391,998	
49	RESPIRATORY THERAPY			1,391,738			324,740	
50	PHYSICAL THERAPY			977,868			26,998	
50 01	CARDIAC REHAB			93,802				
55	MEDICAL SUPPLIES CHARGED			736,005			386,108	
56	DRUGS CHARGED TO PATIENTS			2,164,842			734,720	
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			280,997			505	
61	EMERGENCY			1,398,041			161,514	
62	OBSERVATION BEDS (NON-DIS			164,988			15,536	
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
66	DURABLE MEDICAL EQUIP-REN			360,412				
101	TOTAL			20,456,845			4,149,507	

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES	OUTPAT PROG D,V COL 5.03	OUTPAT PROG D,V COL 5.04	OUTPAT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
LINE NO.		8	8.01	8.02	9	9.01	9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	306,802					
40	ANESTHESIOLOGY	77,935					
41	RADIOLOGY-DIAGNOSTIC	2,070,523					
44	LABORATORY	62,377					
49	RESPIRATORY THERAPY	311,878					
50	PHYSICAL THERAPY						
50	01 CARDIAC REHAB	50,125					
55	MEDICAL SUPPLIES CHARGED	39,912					
56	DRUGS CHARGED TO PATIENTS	693,934					
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	49,812					
61	EMERGENCY	260,666					
62	OBSERVATION BEDS (NON-DIS	28,490					
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN						
101	TOTAL	3,952,454					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 8/31/2008 I PART V
 I 14-0019 I I

TITLE XVIII, PART B

HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
Cost Center Description		1	1.02	2	3	4
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.954488	.954488			
40	ANESTHESIOLOGY	.055342	.055342			
41	RADIOLOGY-DIAGNOSTIC	.236777	.236777			
44	LABORATORY	.278147	.278147			
49	RESPIRATORY THERAPY	.265942	.265942			
50	PHYSICAL THERAPY	.568531	.568531			
50 01	CARDIAC REHAB	1.135690	1.135690			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.073989	.073989			
56	DRUGS CHARGED TO PATIENTS	.601779	.601779			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	1.090449	1.090449			
61	EMERGENCY	.709237	.709237			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.746345	.746345			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
66	DURABLE MEDICAL EQUIP-RENTED	.802723	.802723			
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

	All other (1)	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr
Cost Center Description	5	5.01	5.02	5.03	6
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		306,802			
40 ANESTHESIOLOGY		77,935			
41 RADIOLOGY-DIAGNOSTIC		2,070,523			
44 LABORATORY		62,377			
49 RESPIRATORY THERAPY		311,878			
50 PHYSICAL THERAPY					
50 01 CARDIAC REHAB		50,125			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		39,912			
56 DRUGS CHARGED TO PATIENTS		693,934			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		49,812			
61 EMERGENCY		260,666			
62 OBSERVATION BEDS (NON-DISTINCT PART)		28,490			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED					
101 SUBTOTAL		3,952,454			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		3,952,454			

(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	Outpatient Radiology	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services
	7	8	9	9.01	9.02
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM				292,839	
40 ANESTHESIOLOGY				4,313	
41 RADIOLOGY-DIAGNOSTIC				490,252	
44 LABORATORY				17,350	
49 RESPIRATORY THERAPY				82,941	
50 PHYSICAL THERAPY					
50 01 CARDIAC REHAB				56,926	
55 MEDICAL SUPPLIES CHARGED TO PATIENTS				2,953	
56 DRUGS CHARGED TO PATIENTS				417,595	
OUTPAT SERVICE COST CNTRS					
60 CLINIC				54,317	
61 EMERGENCY				184,874	
62 OBSERVATION BEDS (NON-DISTINCT PART)				21,263	
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
OTHER REIMBURS COST CNTRS					
66 DURABLE MEDICAL EQUIP-RENTED					
101 SUBTOTAL				1,625,623	
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES				1,625,623	

(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

	PPS Services 1/1 to FYE	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9.03	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM			
40 ANESTHESIOLOGY			
41 RADIOLOGY-DIAGNOSTIC			
44 LABORATORY			
49 RESPIRATORY THERAPY			
50 PHYSICAL THERAPY			
50 01 CARDIAC REHAB			50
55 MEDICAL SUPPLIES CHARGED TO PATIENTS			
56 DRUGS CHARGED TO PATIENTS			
OUTPAT SERVICE COST CNTRS			
60 CLINIC			
61 EMERGENCY			
62 OBSERVATION BEDS (NON-DISTINCT PART)			
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
OTHER REIMBURS COST CNTRS			
66 DURABLE MEDICAL EQUIP-RENTED			
101 SUBTOTAL			
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS-			
PROGRAM ONLY CHARGES			
104 NET CHARGES			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 COMPONENT NO: I TO 8/31/2008 I PART II
 14-5565 I I

TITLE XVIII, PART A SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST	NEW CAPITAL RELATED COST	TOTAL CHARGES	INPAT PROGRAM CHARGES	CST/CHRG RATIO	OLD CAPITAL COSTS
LINE NO.		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
50	01 CARDIAC REHAB						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D
 I COMPONENT NO: I TO 8/31/2008 I PART II
 I 14-5565 I

TITLE XVIII, PART A SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	NEW CAPITAL
LINE NO.		CST/CHRG RATIO COSTS
		7 8
	ANCILLARY SRVC COST CNTRS	
37	OPERATING ROOM	
40	ANESTHESIOLOGY	
41	RADIOLOGY-DIAGNOSTIC	
44	LABORATORY	
49	RESPIRATORY THERAPY	
50	PHYSICAL THERAPY	
50	01 CARDIAC REHAB	
55	MEDICAL SUPPLIES CHARGED	
56	DRUGS CHARGED TO PATIENTS	
	OUTPAT SERVICE COST CNTRS	
60	CLINIC	
61	EMERGENCY	
62	OBSERVATION BEDS (NON-DIS	
63	OTHER OUTPATIENT SERVICE	
63	50 RURAL HEALTH CLINIC	
	OTHER REIMBURS COST CNTRS	
66	DURABLE MEDICAL EQUIP-REN	
101	TOTAL	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST		MED ED NRS SCHOOL COST	MED ED ALLIED HEALTH COST	MED ED ALL OTHER COSTS	BLOOD CLOT FOR HEMOPHILIACS
		1	1.01	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
50 01	CARDIAC REHAB						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
60	OUTPAT SERVICE COST CNTRS						
61	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
66	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN						
101	TOTAL						

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF TO CHARGES 5	O/P CST 5.01	RATIO OF TO CHARGES	INPAT CHARGE 6	INPAT PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS								
37	OPERATING ROOM			490,967					
40	ANESTHESIOLOGY			126,776					
41	RADIOLOGY-DIAGNOSTIC			6,416,924				4,216	
44	LABORATORY			5,853,485				23,965	
49	RESPIRATORY THERAPY			1,391,738				15,202	
50	PHYSICAL THERAPY			977,868				63,343	
50	01 CARDIAC REHAB			93,802					
55	MEDICAL SUPPLIES CHARGED			736,005				3,423	
56	DRUGS CHARGED TO PATIENTS			2,164,842				50,366	
	OUTPAT SERVICE COST CNTRS								
60	CLINIC			280,997					
61	EMERGENCY			1,398,041					
62	OBSERVATION BEDS (NON-DIS			164,988					
63	OTHER OUTPATIENT SERVICE								
63	50 RURAL HEALTH CLINIC								
	OTHER REIMBURS COST CNTRS								
66	DURABLE MEDICAL EQUIP-REN			360,412					
101	TOTAL			20,456,845				160,515	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	OUTPUT PROG CHARGES	OUTPUT PROG D,V COL 5.03	OUTPUT PROG D,V COL 5.04	OUTPUT PROG PASS THRU COST	COL 8.01 * COL 5	COL 8.02 * COL 5
	ANCILLARY SRVC COST CNTRS	8	8.01	8.02	9	9.01	9.02
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
50 01	CARDIAC REHAB						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
66	DURABLE MEDICAL EQUIP-REN						
101	TOTAL						

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D-1
 I COMPONENT NO: I TO 8/31/2008 I PART I
 I 14-0019 I I

TITLE XVIII PART A

HOSPITAL

PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,177
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,290
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,290
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,793
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)	94
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,328
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	1,793
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	169.46
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	174.94
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,501,141
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	313,667
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	9,400
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	323,067
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,178,074

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,157,448
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,157,448
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.689821
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	959.71
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,178,074

TITLE XVIII PART A HOSPITAL PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
 PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	662.03
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,541,206
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,541,206

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				
					1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				1,355,991
49	TOTAL PROGRAM INPATIENT COSTS				2,897,197

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	190,570
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	90,286
52	TOTAL PROGRAM EXCLUDABLE COST	280,856
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	2,616,341

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)	313,667
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	313,667
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D-1
 I COMPONENT NO: I TO 8/31/2008 I PART III
 I 14-0019 I I

TITLE XVIII PART A

HOSPITAL

PPS

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

1

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

PART IV - COMPUTATION OF OBSERVATION BED COST

- 83 TOTAL OBSERVATION BED DAYS 186
- 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 662.03
- 85 OBSERVATION BED COST 123,138

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST		2,178,074		123,138	
87 NEW CAPITAL-RELATED COST	309,266	2,178,074	.141991	123,138	17,484
88 NON PHYSICIAN ANESTHETIST		2,178,074		123,138	
89 MEDICAL EDUCATION		2,178,074		123,138	
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET D-1
I	COMPONENT NO:	I	TO 8/31/2008	I	PART I
I	14-5565	I		I	

TITLE XVIII PART A

SNF

PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,004
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,004
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	5,004
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)	573
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	169.46
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	174.94
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	1,069,057
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	1,069,057

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	630,867
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	630,867
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.694584
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	126.07
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	1,069,057

TITLE XVIII PART A SNF PPS

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,069,057
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	213.64
68	PROGRAM ROUTINE SERVICE COST	122,416
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	122,416
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	102,898
72	PER DIEM CAPITAL-RELATED COSTS	20.56
73	PROGRAM CAPITAL-RELATED COSTS	11,781
74	INPATIENT ROUTINE SERVICE COST	110,635
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	110,635
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	122,416
80	PROGRAM INPATIENT ANCILLARY SERVICES	78,281
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	200,697

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				

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET D-4
 I COMPONENT NO: I TO 8/31/2008 I
 I 14-0019 I I

TITLE XVIII, PART A

HOSPITAL

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES	INPATIENT CHARGES	INPATIENT COST
		1	2	3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		2,456,749	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.954488	3,689	3,521
40	ANESTHESIOLOGY	.055342	956	53
41	RADIOLOGY-DIAGNOSTIC	.236777	1,102,743	261,104
44	LABORATORY	.278147	1,391,998	387,180
49	RESPIRATORY THERAPY	.265942	324,740	86,362
50	PHYSICAL THERAPY	.568531	26,998	15,349
50 01	CARDIAC REHAB	1.135690		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.073989	386,108	28,568
56	DRUGS CHARGED TO PATIENTS OUTPAT SERVICE COST CNTRS	.601779	734,720	442,139
60	CLINIC	1.090449	505	551
61	EMERGENCY	.740299	161,514	119,569
62	OBSERVATION BEDS (NON-DISTINCT PART)	.746345	15,536	11,595
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
66	OTHER REIMBURS COST CNTRS DURABLE MEDICAL EQUIP-RENTED	.802723		
101	TOTAL		4,149,507	1,355,991
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		4,149,507	

TITLE XVIII, PART A SWING BED SNF PPS

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			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.954488	2,666	2,545
40	ANESTHESIOLOGY	.055342		
41	RADIOLOGY-DIAGNOSTIC	.236777	128,963	30,535
44	LABORATORY	.278147	317,585	88,335
49	RESPIRATORY THERAPY	.265942	151,455	40,278
50	PHYSICAL THERAPY	.568531	58,871	33,470
50 01	CARDIAC REHAB	1.135690		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.073989	213,578	15,802
56	DRUGS CHARGED TO PATIENTS	.601779	422,839	254,456
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.090449		
61	EMERGENCY	.709237		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.746345		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-RENTED	.802723		
101	TOTAL		1,295,957	465,421
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,295,957	

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

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			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.954488		
40	ANESTHESIOLOGY	.055342		
41	RADIOLOGY-DIAGNOSTIC	.236777	4,216	998
44	LABORATORY	.278147	23,965	6,666
49	RESPIRATORY THERAPY	.265942	15,202	4,043
50	PHYSICAL THERAPY	.568531	63,343	36,012
50 01	CARDIAC REHAB	1.135690		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.073989	3,423	253
56	DRUGS CHARGED TO PATIENTS	.601779	50,366	30,309
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.090449		
61	EMERGENCY	.709237		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.746345		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
66	DURABLE MEDICAL EQUIP-RENTED	.802723		
101	TOTAL		160,515	78,281
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		160,515	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET E
 I COMPONENT NO: I TO 8/31/2008 I PART A
 I 14-0019 I I

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL

DESCRIPTION

	1	1.01
DRG AMOUNT		
1 OTHER THAN OUTLIER PAYMENTS OCCURRING PRIOR TO OCTOBER 1	254,622	
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1	780,841	
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1	2,062,438	
MANAGED CARE PATIENTS		
1.03 PAYMENTS PRIOR TO MARCH 1ST OR OCTOBER 1ST		
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1		
1.05 PAYMENTS ON OR AFTER JANUARY 1ST BUT BEFORE 4/1 / 10/1		
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED (SEE INSTR)		
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001.		
1.08 SIMULATED PAYMENTS FROM PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001.		
2 OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO 10/1/97		
2.01 OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 1997 (SEE INSTRUCTIONS)		
3 BED DAYS AVAILABLE DIVIDED BY # DAYS IN COST RPTG PERIOD	24.49	
INDIRECT MEDICAL EDUCATION ADJUSTMENT		
3.01 NUMBER OF INTERNS & RESIDENTS FROM WKST 5-3, PART I		
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)		
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT		
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996.		
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)		
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)		
FOR CR PERIODS ENDING ON OR AFTER 7/1/2005		
E-3 PT 6 LN 15 PLUS LN 3.06		
3.07 SUM OF LINES 3.04 THROUGH 3.06 (SEE INSTRUCTIONS)		
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS		
3.09 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1.		
3.10 FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCTOBER 1		
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09		
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10		
3.13 FTE COUNT FOR RESIDENTS IN DENTAL AND PODIATRIC PROGRAMS.		
3.14 CURRENT YEAR ALLOWABLE FTE (SEE INSTRUCTIONS)		
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE		
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE		
3.17 SUM OF LINES 3.14 THRU 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO (SEE INSTRUCTIONS).		
3.18 CURRENT YEAR RESIDENT TO BED RATIO (LN 3.17 DIVIDED BY LN 3)		
3.19 PRIOR YEAR RESIDENT TO BED RATIO (SEE INSTRUCTIONS)		
3.20 FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 1997, ENTER THE LESSER OF LINES 3.18 OR 3.19		
3.21 IME PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCT 1		
3.22 IME PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCT 1, BUT BEFORE JANUARY 1 (SEE INSTRUCTIONS)		
3.23 IME PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER JANUARY 1		
	SUM OF LINES	PLUS E-3, PT
	3.21 - 3.23	VI, LINE 23
3.24 SUM OF LINES 3.21 THROUGH 3.23 (SEE INSTRUCTIONS).		
DISPROPORTIONATE SHARE ADJUSTMENT		
4 PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (SEE INSTRUCTIONS)		6.43
4.01 PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET 5-3, PART I		11.90
4.02 SUM OF LINES 4 AND 4.01		18.33
4.03 ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUC)		11.76
4.04 DISPROPORTIONATE SHARE ADJUSTMENT (SEE INSTRUCTIONS)		364,313
ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES		
5 TOTAL MEDICARE DISCHARGES ON WKST 5-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316, AND 317.		
5.01 TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 & 317		
5.02 DIVIDE LINE 5.01 BY LINE 5 (IF LESS THAN 10%, YOU DO NOT QUALIFY FOR ADJUSTMENT)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET E
 I COMPONENT NO: I TO 8/31/2008 I PART A
 I 14-0019 I I

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

HOSPITAL

DESCRIPTION	1	1.01
5.03 TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGS 302, 316, AND 317.		
5.04 RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK		
5.05 AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (SEE INSTRU	335.00	
5.06 TOTAL ADDITIONAL PAYMENT		
6 SUBTOTAL (SEE INSTRUCTIONS)	3,462,214	
7 HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY, SEE INSTRUCTIONS)	3,768,462	
7.01 HOSPITAL SPECIFIC PAYMENTS (TO BE COMPLETED BY SCH AND MDH, SMALL RURAL HOSPITALS ONLY, SEE INSTRUCTIONS) FY BEG. 10/1/2000		
8 TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (SEE INSTRUCTIONS)	3,768,462	
9 PAYMENT FOR INPATIENT PROGRAM CAPITAL	260,968	
10 EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL		
11 DIRECT GRADUATE MEDICAL EDUCATION PAYMENT		
11.01 NURSING AND ALLIED HEALTH MANAGED CARE		
11.02 SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES		
12 NET ORGAN ACQUISITION COST		
13 COST OF TEACHING PHYSICIANS		
14 ROUTINE SERVICE OTHER PASS THROUGH COSTS		
15 ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
16 TOTAL	4,029,430	
17 PRIMARY PAYER PAYMENTS	485	
18 TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES	4,028,945	
19 DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	510,067	
20 COINSURANCE BILLED TO PROGRAM BENEFICIARIES	2,843	
21 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	72,936	
21.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	51,055	
21.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	72,936	
22 SUBTOTAL	3,567,090	
23 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
24 OTHER ADJUSTMENTS (SPECIFY)		
24.99 OUTLIER RECONCILIATION ADJUSTMENT		
25 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
26 AMOUNT DUE PROVIDER	3,567,090	
27 SEQUESTRATION ADJUSTMENT		
28 INTERIM PAYMENTS	3,498,298	
28.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
29 BALANCE DUE PROVIDER (PROGRAM)	68,792	
30 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		
----- FI ONLY -----		
50 OPERATING OUTLIER AMOUNT FROM WKS E, A, L2.01		
51 CAPITAL OUTLIER AMOUNT FROM WKS L, I, L3.01		
52 OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)		
53 CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)		
54 THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY		
55 TIME VALUE OF MONEY (SEE INSTRUCTIONS)		
56 CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET E
I	COMPONENT NO:	I	TO 8/31/2008	I	PART B
I	14-0019	I		I	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)		
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	1,625,623	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	368,654	737,307
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	.849	.849
1.04	LINE 1.01 TIMES LINE 1.03.	1,380,154	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	26.71	
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)		

COMPUTATION OF LESSER OF COST OR CHARGES

6	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		
11	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)		
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	1,105,961	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)		13
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	318,969	
19	SUBTOTAL (SEE INSTRUCTIONS)	786,979	
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	786,979	
24	PRIMARY PAYER PAYMENTS	165	
25	SUBTOTAL	786,814	
26	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD		
27	BAD DEBTS (SEE INSTRUCTIONS)	21,091	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	14,764	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	21,091	
28	SUBTOTAL	801,578	
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	801,578	
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
34	INTERIM PAYMENTS	833,426	
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
35	BALANCE DUE PROVIDER/PROGRAM	-31,848	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET E-1
 I COMPONENT NO: I TO 8/31/2008 I
 I 14-0019 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		3,498,298		833,426
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		NONE		NONE
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .59				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		3,498,298		833,426
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

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 SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		144,279		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		144,279		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		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:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

TITLE XVIII SWING BED SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		510,472		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL .99		NONE		NONE
4 TOTAL INTERIM PAYMENTS		510,472		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL .99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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

CALCULATION OF REIMBURSEMENT SETTLEMENT
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I
 I COMPONENT NO: I TO 8/31/2008 I WORKSHEET E-2
 I 14-U019 I I

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)	561,056	
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	1,793	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	561,056	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	561,056	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	561,056	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	50,584	
14	80% OF PART B COSTS		
15	SUBTOTAL	510,472	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS	10,534	
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	10,534	
18	TOTAL	521,006	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	510,472	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	10,534	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET E-3
 I COMPONENT NO: I TO 8/31/2008 I PART III
 I 14-5565 I I

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 8/31/2008	I	PART III
I	14-5565	I		I	

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

TITLE XVIII

SNF

PPS
 TITLE V OR
 TITLE XIX
 1

TITLE XVIII
 SNF PPS
 2

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	2,236,227			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,701,195			
5	OTHER RECEIVABLES	56,467			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,621,575			
7	INVENTORY	249,858			
8	PREPAID EXPENSES	301,624			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	4,923,796			
FIXED ASSETS					
12	LAND	784,709			
12.01	LAND IMPROVEMENTS				
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION	-330,600			
14	BUILDINGS	11,058,886			
14.01	LESS ACCUMULATED DEPRECIATION	-5,399,572			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT	3,692,261			
16.01	LESS ACCUMULATED DEPRECIATION	-2,561,802			
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT	7,682,596			
18.01	LESS ACCUMULATED DEPRECIATION	-6,742,078			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	8,184,400			
OTHER ASSETS					
22	INVESTMENTS	18,437,098			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	1,358,600			
26	TOTAL OTHER ASSETS	19,795,698			
27	TOTAL ASSETS	32,903,894			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I
 I TO 8/31/2008 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	307,523			
29 SALARIES, WAGES & FEES PAYABLE	360,432			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	200,000			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	61,282			
35 OTHER CURRENT LIABILITIES	150,465			
36 TOTAL CURRENT LIABILITIES	1,079,702			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	7,525,000			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	7,525,000			
43 TOTAL LIABILITIES	8,604,702			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	24,299,192			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	24,299,192			
52 TOTAL LIABILITIES AND FUND BALANCES	32,903,894			

STATEMENT OF CHANGES IN FUND BALANCES

	GENERAL FUND		SPECIFIC PURPOSE FUND	
	1	2	3	4
1 FUND BALANCE AT BEGINNING		24,728,258		
2 OF PERIOD				
2 NET INCOME (LOSS)		-429,066		
3 TOTAL		24,299,192		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL		24,299,192		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF		24,299,192		
PERIOD PER BALANCE SHEET				

	ENDOWMENT FUND		PLANT FUND	
	5	6	7	8
1 FUND BALANCE AT BEGINNING				
2 OF PERIOD				
2 NET INCOME (LOSS)				
3 TOTAL				
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM				
6				
7				
8				
9				
10 TOTAL ADDITIONS				
11 SUBTOTAL				
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
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
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,157,448		3,157,448
4 00 SWING BED - SNF	1,329,963		1,329,963
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	630,867		630,867
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	5,118,278		5,118,278
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	5,118,278		5,118,278
17 00 ANCILLARY SERVICES	6,198,537		6,198,537
18 00 OUTPATIENT SERVICES		15,469,078	15,469,078
18 50 RURAL HEALTH CLINIC		493,425	493,425
19 00 HOME HEALTH AGENCY		357,708	357,708
24 00			
25 00 TOTAL PATIENT REVENUES	11,316,815	16,320,211	27,637,026

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		14,566,527	
ADD (SPECIFY)			
27 00 BAD DEBTS	1,243,658		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		1,243,658	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		15,810,185	

STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/ 6/2008
I	14-0019	I	FROM 9/ 1/2007	I	WORKSHEET G-3
I		I	TO 8/31/2008	I	

DESCRIPTION

1	TOTAL PATIENT REVENUES	27,637,026
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	12,226,681
3	NET PATIENT REVENUES	15,410,345
4	LESS: TOTAL OPERATING EXPENSES	15,810,185
5	NET INCOME FROM SERVICE TO PATIENTS	-399,840
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	65,827
7	INCOME FROM INVESTMENTS	1,306,060
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	48,197
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	2,347
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	11,298
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	82,738
23	GOVERNMENTAL APPROPRIATIONS	
24	FARM INCOME	82,146
24.01	LIFELINE INCOME	28,892
24.02	NURSING SERVICES	26,156
24.03	PROFESSIONAL FEES	3,000
24.04	MISCELLANEOUS INCOME	4,679
24.05	SICK BAY INCOME	38
25	TOTAL OTHER INCOME	1,661,378
26	TOTAL	1,261,538
	OTHER EXPENSES	
27	UNREALIZED LOSSES	1,690,604
28		
29		
30	TOTAL OTHER EXPENSES	1,690,604
31	NET INCOME (OR LOSS) FOR THE PERIOD	-429,066

HHA 1

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPORTATION 3	CONTRACTED/ PURCHASED SVCS 4	OTHER COSTS 5	TOTAL 6
GENERAL SERVICE COST CENTERS						
1						
2						
3						
4						
5	81,474				11,944	93,418
HHA REIMBURSABLE SERVICES						
6	102,092					102,092
7	30,661		20,187			50,848
8				1,204		1,204
9				525		525
10	1,729					1,729
11	21,083					21,083
12						
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23	8,076				29,121	37,197
23.50						
24	245,115		20,187	1,729	41,065	308,096

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5	-4,035	89,383		89,383
HHA REIMBURSABLE SERVICES				
6		102,092	-26,156	75,936
7		50,848		50,848
8		1,204		1,204
9		525		525
10	-1,152	577		577
11		21,083		21,083
12				
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23		37,197	-29,121	8,076
23.50				
24	-5,187	302,909	-55,277	247,632

HHA 1

	CAP-REL COST-BLDG & FIX (SQUARE FEET)	CAP-REL COST-MOV EQUIP (DOLLAR VALUE)	PLANT OPER & MAINT (SQUARE FEET)	TRANSPORTATIO N (MILEAGE)	RECONCILIATIO N (5A	ADMINISTRATIV E & GENERAL (ACCUM. COST)
	1	2	3	4		5
GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX					
2	CAP-REL COST-MOV EQUIP					
3	PLANT OPER & MAINT					
4	TRANSPORTATION					
5	ADMINISTRATIVE & GENERAL				-89,383	158,249
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE					75,936
7	PHYSICAL THERAPY					50,848
8	OCCUPATIONAL THERAPY					1,204
9	SPEECH PATHOLOGY					525
10	MEDICAL SOCIAL SERVICES					577
11	HOME HEALTH AIDE					21,083
12	SUPPLIES					
13	DRUGS					
13.20	COST ADMINISTERING DRUGS					
14	DME					
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS					
16	RESPIRATORY THERAPY					
17	PRIVATE DUTY NURSING					
18	CLINIC					
19	HEALTH PROM ACTIVITIES					
20	DAY CARE PROGRAM					
21	HOME DEL MEALS PROGRAM					
22	HOMEMAKER SERVICE					
23	ALL OTHERS					8,076
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)				-89,383	158,249
25	COST TO BE ALLOCATED					89,383
26	UNIT COST MULTIPLIER					.564825

HHA 1

HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BEN EFITS 5	SUBTOTAL 5A	ADMINISTRATI VE & GENERAL 6
1 ADMIN & GENERAL		6,726	8,548	11,964	27,238	5,067
2 SKILLED NURSING CARE	118,826			14,992	133,818	24,895
3 PHYSICAL THERAPY	79,568			4,503	84,071	15,641
4 OCCUPATIONAL THERAPY	1,884				1,884	351
5 SPEECH PATHOLOGY	822				822	153
6 MEDICAL SOCIAL SERVICES	903			85	988	184
7 HOME HEALTH AIDE	32,991			3,096	36,087	6,714
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER	12,638			1,186	13,824	2,572
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	247,632	6,726	8,548	35,826	298,732	55,577
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	MAINTENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LI NEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12
1 ADMIN & GENERAL	6,728	6,775		5,006		38,419
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)	6,728	6,775		5,006		38,419
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NURSING ADMINISTRATION 14	CENTRAL SERVICES & SUPPL 15	MEDICAL RECORDS & LIBRAR 17	NONPHYSICIAN ANESTHETIST 20	SUBTOTAL 25	POST STEP DOWN ADJUST 26
1 ADMIN & GENERAL		345			89,578	
2 SKILLED NURSING CARE					158,713	
3 PHYSICAL THERAPY					99,712	
4 OCCUPATIONAL THERAPY					2,235	
5 SPEECH PATHOLOGY					975	
6 MEDICAL SOCIAL SERVICES					1,172	
7 HOME HEALTH AIDE					42,801	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER					16,396	
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19) (2)		345			411,582	
21 UNIT COST MULTIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA COST CENTER	SUBTOTAL 27	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL	89,578		
2 SKILLED NURSING CARE	158,713	44,152	202,865
3 PHYSICAL THERAPY	99,712	27,739	127,451
4 OCCUPATIONAL THERAPY	2,235	622	2,857
5 SPEECH PATHOLOGY	975	271	1,246
6 MEDICAL SOCIAL SERVICES	1,172	326	1,498
7 HOME HEALTH AIDE	42,801	11,907	54,708
8 SUPPLIES			
9 DRUGS			
9.20 COST ADMINISTERING DRUGS			
10 DME			
11 HOME DIALYSIS AIDE SVCS			
12 RESPIRATORY THERAPY			
13 PRIVATE DUTY NURSING			
14 CLINIC			
15 HEALTH PROM ACTIVITIES			
16 DAY CARE PROGRAM			
17 HOME DEL MEALS PROGRAM			
18 HOMEMAKER SERVICE			
19 ALL OTHER	16,396	4,561	20,957
19.50 TELEMEDICINE			
20 TOTAL (SUM OF 1-19) (2)	411,582	89,578	411,582
21 UNIT COST MULTIPLIER		0.278189	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.

(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE (SQUARE FEET) 4	EMPLOYEE BEN EFITS (GROSS SALARIES) 5	RECONCILIATI ON 6A	ADMINISTRATI VE & GENERAL (ACCUM. COST) 6	MAINTENANCE & REPAIRS (SQUARE FEET) 7
1 ADMIN & GENERAL	800	800	81,474		27,238	800
2 SKILLED NURSING CARE			102,092		133,818	
3 PHYSICAL THERAPY			30,661		84,071	
4 OCCUPATIONAL THERAPY					1,884	
5 SPEECH PATHOLOGY					822	
6 MEDICAL SOCIAL SERVICES			577		988	
7 HOME HEALTH AIDE			21,083		36,087	
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER			8,076		13,824	
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	800	800	243,963		298,732	800
21 COST TO BE ALLOCATED	6,726	8,548	35,826		55,577	6,728
22 UNIT COST MULTIPLIER	8.407500	10.685000	0.146850		0.186043	8.410000

HHA COST CENTER	OPERATION OF PLANT (SQUARE FEET) 8	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (SQUARE FEET) 10	DIETARY (MEALS SERVED) 11	CAFETERIA (MAN OURS) 12	NURSING ADMI NISTRATION H (DIRECT NRSING HRS) 14
1 ADMIN & GENERAL	800		800		25,845	
2 SKILLED NURSING CARE						
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES						
9 DRUGS						
9.20 COST ADMINISTERING DRUGS						
10 DME						
11 HOME DIALYSIS AIDE SVCS						
12 RESPIRATORY THERAPY						
13 PRIVATE DUTY NURSING						
14 CLINIC						
15 HEALTH PROM ACTIVITIES						
16 DAY CARE PROGRAM						
17 HOME DEL MEALS PROGRAM						
18 HOMEMAKER SERVICE						
19 ALL OTHER						
19.50 TELEMEDICINE						
20 TOTAL (SUM OF 1-19)	800		800		25,845	
21 COST TO BE ALLOCATED	6,775		5,006		38,419	
22 UNIT COST MULTIPLIER	8.468750		6.257500		1.486516	

Health Financial Systems MCRIF32
 ALLOCATION OF GENERAL SERVICE
 COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

FOR SHELBY MEMORIAL HOSPITAL

IN LIEU OF FORM CMS-2552-96 (05/2007)

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET H-5
 I HHA NO: I TO 8/31/2008 I PART II
 I 14-7622 I I

HHA 1

HHA COST CENTER	CENTRAL SERV	MEDICAL RECO	NONPHYSICIAN
	ICES & SUPPL	RDS & LIBRAR	ANESTHETIST
	(COSTED)	(TIME)	(ASSIGNED)
	REQUIS.	SPENT	TIME
	15	17	20
1 ADMIN & GENERAL	555		
2 SKILLED NURSING CARE			
3 PHYSICAL THERAPY			
4 OCCUPATIONAL THERAPY			
5 SPEECH PATHOLOGY			
6 MEDICAL SOCIAL SERVICES			
7 HOME HEALTH AIDE			
8 SUPPLIES			
9 DRUGS			
9.20 COST ADMINISTERING DRUGS			
10 DME			
11 HOME DIALYSIS AIDE SVCS			
12 RESPIRATORY THERAPY			
13 PRIVATE DUTY NURSING			
14 CLINIC			
15 HEALTH PROM ACTIVITIES			
16 DAY CARE PROGRAM			
17 HOME DEL MEALS PROGRAM			
18 HOMEMAKER SERVICE			
19 ALL OTHER			
19.50 TELEMEDICINE			
20 TOTAL (SUM OF 1-19)	555		
21 COST TO BE ALLOCATED	345		
22 UNIT COST MULTIPLIER	0.621622		

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET H-6
 I HHA NO: I TO 8/31/2008 I PARTS I II & III
 I 14-7622 I I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

COST PER VISIT COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS
							PART A 6
1 SKILLED NURSING	2	202,865	2	202,865	1,151	176.25	613
2 PHYSICAL THERAPY	3	127,451		127,451	1,125	113.29	816
3 OCCUPATIONAL THERAPY	4	2,857		2,857	17	168.06	15
4 SPEECH PATHOLOGY	5	1,246		1,246	7	178.00	7
5 MEDICAL SOCIAL SERVICES	6	1,498		1,498	1	1,498.00	
6 HOME HEALTH AIDE SERVICE	7	54,708		54,708	838	65.28	221
7 TOTAL		390,625		390,625	3,139		1,672

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	
1 SKILLED NURSING	7	189	108,041	10	141,352
2 PHYSICAL THERAPY		134	92,445	15,181	107,626
3 OCCUPATIONAL THERAPY			2,521		2,521
4 SPEECH PATHOLOGY			1,246		1,246
5 MEDICAL SOCIAL SERVICES					
6 HOME HEALTH AIDE SERVICES		452	14,427	29,507	43,934
7 TOTAL		775	218,680	77,999	296,679

LIMITATION COST COMPUTATION	1	2	3	4	PROGRAM COST LIMITS	PROGRAM VISITS
					5	PART A 6
8 SKILLED NURSING	9914					
9 PHYSICAL THERAPY	9914					
10 OCCUPATIONAL THERAPY	9914					
11 SPEECH PATHOLOGY	9914					
12 MEDICAL SOCIAL SERVICES	9914					
13 HOME HEALTH AIDE SERVICE	9914					
14 TOTAL						

	-----PROGRAM VISITS-----		-----COST OF SERVICES-----		TOTAL PROGRAM COST
	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	
8 SKILLED NURSING	7	8	9	10	11
9 PHYSICAL THERAPY					
10 OCCUPATIONAL THERAPY					
11 SPEECH PATHOLOGY					
12 MEDICAL SOCIAL SERVICES					
13 HOME HEALTH AIDE SERVICE					
14 TOTAL					

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET H-6
 I HHA NO: I TO 8/31/2008 I PARTS I II & III
 I 14-7622 I I HHA 1

[] TITLE V [X] TITLE XVIII [] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
 COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

SUPPLIES AND EQUIPMENT COST COMPUTATION	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I) 1	SHARED ANCILLARY COSTS (FROM PART II) 2	TOTAL HHA COSTS 3	TOTAL CHARGES 4	RATIO 5	PROGRAM COVERED CHARGES PART A 6
15 COST OF MEDICAL SUPPLIES	8.00						
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES -----PART B-----		-----COST OF SERVICES----- -----PART B-----		
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	PART A 9	NOT SUBJECT TO DEDUCT & COINSUR 10	SUBJECT TO DEDUCT & COINSUR 11
15 COST OF MEDICAL SUPPLIES					
16 COST OF DRUGS					
16.20 COST OF DRUGS					

PER BENEFICIARY COST LIMITATION:	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UN DUP CENSUS FROM WRKST S-4	9914	
17 PER BENE COST LIMITATION (FRM FI)	9914	
18 PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

	FROM WKST C PT I, COL 9	COST TO CHARGE RATIO 1	TOTAL HHA CHARGES 2	HHA SHARED ANCILLARY COSTS 3	TRANSFER TO PART I AS INDICATED 4
1 PHYSICAL THERAPY	50	.568531			COL 2, LN 2
1.01 CARDIAC REHAB	50.01	1.135690			
2 OCCUPATIONAL THERAPY	51				COL 2, LN 3
3 SPEECH PATHOLOGY	52				COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.073989			COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.601779			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

	FROM PART I, COL 5 1	COST PER VISIT 2	----- PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE -----		----- PROGRAM COSTS -----		PROG VISITS ON OR AFTER 1/1/1999 5
			PRIOR 1/1/1998 3	1/1/1998 TO 12/31/1998 4	PRIOR 1/1/1998 3	1/1/1998 TO 12/31/1998 4	
1 PHYSICAL THERAPY	2	113.29	2.01	3	3.01	4	
2 OCCUPATIONAL THERAPY	3	168.06					
3 SPEECH PATHOLOGY	4	178.00					
4 TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/ 6/2008
I 14-0019	I FROM 9/ 1/2007	I WORKSHEET H-7
I HHA NO:	I TO 8/31/2008	I PARTS I & II
I 14-7622	I	I

TITLE XVIII

HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO DED & COINS
	1	2	3
1 REASONABLE COST OF SERVICES			
2 TOTAL CHARGES			
3 CUSTOMARY CHARGES			
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
5 AMOUNT 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(B)			
6 RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
7 TOTAL CUSTOMARY CHARGES			
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST			
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
10 PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES	PART B SERVICES
	1	2
10 TOTAL REASONABLE COST		
10.01 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	262,910	73,867
10.02 TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.03 TOTAL PPS REIMBURSEMENT-LUPA EPISODES	1,090	724
10.04 TOTAL PPS REIMBURSEMENT-PEP EPISODES	2,387	
10.05 TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06 TOTAL PPS REIMBURSEMENT-SCIC EPISODES	278	
10.07 TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS		
10.08 TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10 TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11 TOTAL OTHER PAYMENTS		
10.12 DME PAYMENTS		
10.13 OXYGEN PAYMENTS		
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS		
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12 SUBTOTAL	266,665	74,591
13 EXCESS REASONABLE COST		
14 SUBTOTAL	266,665	74,591
15 COINSURANCE BILLED TO PROGRAM PATIENTS		
16 NET COST	266,665	74,591
17 REIMBURSABLE BAD DEBTS		
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	266,665	74,591
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21 OTHER ADJUSTMENTS (SPECIFY)		
22 SUBTOTAL	266,665	74,591
23 SEQUESTRATION ADJUSTMENT		
24 SUBTOTAL	266,665	74,591
25 INTERIM PAYMENTS	266,665	74,591
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE PROVIDER/PROGRAM		
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

TITLE XVIII HHA 1

DESCRIPTION	P A R T A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		266,665		74,591
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		266,665		74,591
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT				
AMOUNT (BALANCE DUE)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
BASED ON COST REPORT (1)				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

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.

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET L
 I COMPONENT NO: I TO 8/31/2008 I PARTS I-IV
 I 14-0019 I I

CALCULATION OF CAPITAL PAYMENT

TITLE XVIII, PART A HOSPITAL

FULLY PROSPECTIVE METHOD

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS	
	CAPITAL FEDERAL AMOUNT	
2	CAPITAL DRG OTHER THAN OUTLIER	260,968
3	CAPITAL DRG OUTLIER PAYMENTS PRIOR TO 10/01/1997	
3 .01	CAPITAL DRG OUTLIER PAYMENTS AFTER 10/01/1997	
	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS	8.48
	IN THE COST REPORTING PERIOD	
4 .01	NUMBER OF INTERNS AND RESIDENTS	.00
	(SEE INSTRUCTIONS)	
4 .02	INDIRECT MEDICAL EDUCATION PERCENTAGE	.00
4 .03	INDIRECT MEDICAL EDUCATION ADJUSTMENT	
	(SEE INSTRUCTIONS)	
5	PERCENTAGE OF SSI RECEIPIENT PATIENT DAYS TO	.00
	MEDICARE PART A PATIENT DAYS	
5 .01	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL	.00
	DAYS REPORTED ON S-3, PART I	
5 .02	SUM OF 5 AND 5.01	.00
5 .03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE	.00
5 .04	DISPROPORTIONATE SHARE ADJUSTMENT	
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS	260,968

PART II - HOLD HARMLESS METHOD

1	NEW CAPITAL	
2	OLD CAPITAL	
3	TOTAL CAPITAL	
4	RATIO OF NEW CAPITAL TO OLD CAPITAL	.000000
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE	
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT	
7	REDUCED OLD CAPITAL AMOUNT	
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL	
9	SUBTOTAL	
10	PAYMENT UNDER HOLD HARMLESS	

PART III - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST	
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST	
3	TOTAL INPATIENT PROGRAM CAPITAL COST	
4	CAPITAL COST PAYMENT FACTOR	
5	TOTAL INPATIENT PROGRAM CAPITAL COST	

PART IV - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS	
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY	
	CIRCUMSTANCES	
3	NET PROGRAM INPATIENT CAPITAL COSTS	
4	APPLICABLE EXCEPTION PERCENTAGE	.00
5	CAPITAL COST FOR COMPARISON TO PAYMENTS	
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY	.00
	CIRCUMSTANCES	
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL	
	FOR EXTRAORDINARY CIRCUMSTANCES	
8	CAPITAL MINIMUM PAYMENT LEVEL	
9	CURRENT YEAR CAPITAL PAYMENTS	
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT	
	LEVEL TO CAPITAL PAYMENTS	
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT	
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL	
	TO CAPITAL PAYMENTS	
13	CURRENT YEAR EXCEPTION PAYMENT	
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT	
	LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD	
15	CUR YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT	
16	CURRENT YEAR OPERATING AND CAPITAL COSTS	
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT	
	(SEE INSTRUCTIONS)	

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	155,848		155,848	
3	75,269		75,269	
4				
5	50,116		50,116	
6				
7				
8				
9	684		684	
10	281,917		281,917	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15				
16		17,453	17,453	
17		949	949	
18				
19		2,080	2,080	
20				
21		20,482	20,482	
22	281,917	20,482	302,399	
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
FACILITY OVERHEAD				
29		686	686	
30	101,688	7,188	108,876	-3,966
31	101,688	7,874	109,562	-3,966
32	383,605	28,356	411,961	-3,966

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	155,848		155,848
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	75,269		75,269
5 VISITING NURSE			
6 OTHER NURSE	50,116		50,116
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS	684		684
10 SUBTOTAL (SUM OF LINES 1-9)	281,917		281,917
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	17,453		17,453
17 TRANSPORTATION (HEALTH CARE STAFF)	949		949
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE			
20 OTHER HEALTH CARE COSTS	2,080		2,080
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	20,482		20,482
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	302,399		302,399
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY			
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 FACILITY OVERHEAD			
30 FACILITY COSTS	686		686
31 ADMINISTRATIVE COSTS	104,910		104,910
32 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	105,596		105,596
TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	407,995		407,995

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET M-2
I COMPONENT NO: I TO 8/31/2008 I
I 14-3446 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
POSITIONS				
1	PHYSICIANS	1.00	3,280	4,200
2	PHYSICIAN ASSISTANTS			2,100
3	NURSE PRACTITIONERS	1.00	3,001	2,100
4	SUBTOTAL (SUM OF LINES 1-3)	2.00	6,281	6,300
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	2.00	6,281	
9	PHYSICIAN SERVICES UNDER AGREEMENTS			
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	302,399		
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)			
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	302,399		
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000		
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	105,596		
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	302,794		
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	408,390		
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)			
18	SUBTRACT LINE 17 FROM LINE 16	408,390		
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	408,390		
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	710,789		
			GREATER OF COL. 2 OR COL. 4 5	
POSITIONS				
1	PHYSICIANS			
2	PHYSICIAN ASSISTANTS			
3	NURSE PRACTITIONERS			
4	SUBTOTAL (SUM OF LINES 1-3)	6,300		
5	VISITING NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	6,300		
9	PHYSICIAN SERVICES UNDER AGREEMENTS			

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

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	710,789
	(FROM WORKSHEET M-2, LINE 20)	
2	COST OF VACCINES AND THEIR ADMINISTRATION	4,287
	(FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	706,502
	(LINE 1 MINUS LINE 2)	
4	TOTAL VISITS	6,300
	(FROM WORKSHEET M-2, COLUMN 5, LINE 8)	
5	PHYSICIANS VISITS UNDER AGREEMENT	
	(FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	6,300
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	112.14

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	74.29 75.63
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	112.14 112.14
10	CALCULATION OF SETTLEMENT	
	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	572 1,144
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	64,144 128,288
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	192,432
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	20,870
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	171,562
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	137,250
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	1,819
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	139,069
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	2,298
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	2,298
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	141,367
25	INTERIM PAYMENTS	135,396
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	5,971
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

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

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

COMPUTATION OF PNEUMOCOCCAL AND
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
I 14-0019 I FROM 9/ 1/2007 I WORKSHEET M-4
I COMPONENT NO: I TO 8/31/2008 I
I 14-3446 I I

TITLE XVIII

RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	281,917	281,917
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		.001896
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)		535
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)		1,289
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		1,824
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	302,399	302,399
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	408,390	408,390
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		.006032
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)		2,463
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)		4,287
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		99
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)		43.30
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		42
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		1,819
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		4,287
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		1,819

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR
 SERVICES RENDERED TO PROGRAM BENEFICIARIES
 [X] RHC [] FQHC

I PROVIDER NO: I PERIOD: I PREPARED 11/ 6/2008
 I 14-0019 I FROM 9/ 1/2007 I WORKSHEET M-5
 I COMPONENT NO: I TO 8/31/2008 I
 I 14-3446 I I

RHC 1

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	131,550
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER .01	12/17/2007		3,846
ADJUSTMENTS TO PROVIDER .02			
ADJUSTMENTS TO PROVIDER .03			
ADJUSTMENTS TO PROVIDER .04			
ADJUSTMENTS TO PROVIDER .05			
ADJUSTMENTS TO PROGRAM .50			
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
SUBTOTAL .99			3,846
4 TOTAL INTERIM PAYMENTS			135,396
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER .01			
TENTATIVE TO PROVIDER .02			
TENTATIVE TO PROVIDER .03			
TENTATIVE TO PROGRAM .50			
TENTATIVE TO PROGRAM .51			
TENTATIVE TO PROGRAM .52			
SUBTOTAL .99			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		
	SETTLEMENT TO PROGRAM .02		
7 TOTAL MEDICARE PROGRAM LIABILITY			

NAME OF INTERMEDIARY:
 INTERMEDIARY NO:

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.