Health Financial Systems MCRIF32 FOR MERCER COUNTY HOSPITAL

IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 11/23/2008 14:48

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 COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1304	PERIOD FROM 7/ 1/2007 TO 6/30/2008	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / /	INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/23/2008 TIME 14:48

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 IMPRISIONMENT 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:
MERCER COUNTY HOSPITAL 14-1304
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 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: 11/23/2008 TIME 14:48

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

CEO
TITLE

11-26-08
DATE

RECEIVED
NOV 26 2008
Healthcare & Family Services
BUREAU OF HEALTH FINANCE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	-4,315	42,396	0
3	SWING BED - SNF	0	66,600	0	0
7	HOSPITAL-BASED HHA	0	0	0	0
9	RHC	0	0	106,752	0
100	TOTAL	0	62,285	149,148	0

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

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THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
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ELECTRONICALLY FILED COST REPORT DATE: 11/23/2008 TIME 14:48

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MERCER COUNTY HOSPITAL 14-1304
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DATE: 11/23/2008 TIME 14:48

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PI ENCRYPTION INFORMATION
DATE: 11/23/2008 TIME 14:48

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OvnC6YdBYw0sWGp6

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	A TITLE XVIII	B TITLE XIX	
		1	2	3	4
1	HOSPITAL	0	-4,315	42,396	0
3	SWING BED - SNF	0	66,600	0	0
7	HOSPITAL-BASED HHA	0	0	0	0
9	RHC	0	0	106,752	0
100	TOTAL	0	62,285	149,148	0

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 409 N.W. NINTH AVENUE P.O. BOX:
1.01 CITY: ALEDO STATE: IL ZIP CODE: 61231- COUNTY: MERCER

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	MERCER COUNTY HOSPITAL	14-1304		5/ 1/2000	N	O	O
04.00	SWING BED - SNF	MERCER COUNTY HOSPITAL	14-Z304		5/ 1/2000	N	O	N
09.00	HOSPITAL-BASED HHA	MERCER COUNTY HOSPITAL	14-7462		1/ 6/1987	N	P	N
12.00	HOSP-BASED HOSPICE	MERCER COUNTY HOSPITAL	14-1593		9/ 5/1997			
14.00	HOSPITAL-BASED RHC	MERCER COUNTY HOSPITAL	14-3453		2/29/2000	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2007 TO: 6/30/2008

		1	2
18	TYPE OF CONTROL	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?			
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION 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.			
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	1		
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	1		
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.			
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.			
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			

25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)		
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0	
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /	
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /	
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	5/ 1/2000
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02		
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1 0	2 0.0000
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0

A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)

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

MISCELLANEOUS COST REPORT INFORMATION

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

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

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

TITLE XIX INPATIENT SERVICES

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

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COL 2 THE HOME OFFICE PROVIDER NUMBER. IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION ENTER THE NAME AND ADDRESS OF THE HOME OFFICE	Y	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE: -		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	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? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

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

		PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
		1	2	3	4	5
47.00	HOSPITAL	N	N	N	N	N
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:	154,309	
	PAID LOSSES:	0	
	AND/OR SELF INSURANCE:	0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N	
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N	

		DATE	Y OR N	LIMIT	Y OR N	FEES
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

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

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

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 COL1. 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: 14-1304 PERIOD: FROM 7/ 1/2007 TO 6/30/2008 PREPARED 11/23/2008 WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	25	9,150	19,970.00		622		35
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					811		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	25	9,150	19,970.00		1,433		35
12	TOTAL	25	9,150	19,970.00		1,433		35
13	RPCH VISITS							
17	OTHER LONG TERM CARE	14	5,124					
18	HOME HEALTH AGENCY					2,345		129
21	HOSPICE							
24	RURAL HEALTH CLINIC					3,305		3,806
25	TOTAL	39						
26	OBSERVATION BED DAYS							14
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I/P DAYS / O/P VISITS / TRIPS TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	TOTAL ALL PATS 6	TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			848				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			811				
4	ADULTS & PED-SB NF			158				
5	TOTAL ADULTS AND PEDS			1,817				
12	TOTAL			1,817				
13	RPCH VISITS							
17	OTHER LONG TERM CARE			4,038				
18	HOME HEALTH AGENCY			5,667				
21	HOSPICE							
24	RURAL HEALTH CLINIC			13,794				
25	TOTAL							
26	OBSERVATION BED DAYS	4	10	141	12	129		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					195	18	279
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		103.59			195	18	279
13	RPCH VISITS							
17	OTHER LONG TERM CARE		10.26					15
18	HOME HEALTH AGENCY		7.38					
21	HOSPICE		.85					
24	RURAL HEALTH CLINIC		12.92					
25	TOTAL		135.00					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO:	I PERIOD:		I PREPARED	11/23/2008
I 14-1304	I FROM	7/ 1/2007	I WORKSHEET	S-4
I HHA NO:	I TO	6/30/2008	I	
I 14-7462	I		I	
COUNTY:	MERCER			

HHA 1

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1	HOME HEALTH AIDE HOURS	0	1,976	33	396
2	UNDUPLICATED CENSUS COUNT		114.00	5.00	28.00

		TOTAL 5
1	HOME HEALTH AIDE HOURS	2,405
2	UNDUPLICATED CENSUS COUNT	147.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

		STAFF 1	CONTRACT 2	TOTAL 3
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)			
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5	OTHER ADMINISTRATIVE PERSONEL	2.32		2.32
6	DIRECTING NURSING SERVICE	3.06		3.06
7	NURSING SUPERVISOR			
8	PHYSICAL THERAPY SERVICE			
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	1.49		1.49
17	HOME HEALTH AIDE SUPERVISOR			
18	HOMEMAKER	.84		.84
	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?	0	1	
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).		19340	

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

		FULL EPISODES WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21	SKILLED NURSING VISITS	1,181	149	32	23
22	SKILLED NURSING VISIT CHARGES	124,320	15,645	3,360	2,415
23	PHYSICAL THERAPY VISITS	159	10	0	0
24	PHYSICAL THERAPY VISIT CHARGES	18,480	1,155	0	0
25	OCCUPATIONAL THERAPY VISITS	15	0	0	0
26	OCCUPATIONAL THERAPY VISIT CHARGES	1,872	0	0	0
27	SPEECH PATHOLOGY VISITS	0	0	0	0
28	SPEECH PATHOLOGY VISIT CHARGES	0	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	752	0	4	8
32	HOME HEALTH AIDE VISIT CHARGES	39,481	0	210	420
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	2,107	159	36	31
34	OTHER CHARGES	5,838	1,270	0	72
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	189,991	18,070	3,570	2,907
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	133	0	11	2
37	TOTAL NUMBER OF OUTLIER EPISODES	0	3	0	0
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	259,908	9,332	3,173	1,954

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO: 14-1304 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 11/23/2008 | WORKSHEET S-4

HHA NO: 14-7462 | COUNTY: MERCER

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	9	1,394
22	SKILLED NURSING VISIT CHARGES	0	945	146,685
23	PHYSICAL THERAPY VISITS	0	0	169
24	PHYSICAL THERAPY VISIT CHARGES	0	0	19,635
25	OCCUPATIONAL THERAPY VISITS	0	0	15
26	OCCUPATIONAL THERAPY VISIT CHARGES	0	0	1,872
27	SPEECH PATHOLOGY VISITS	0	0	0
28	SPEECH PATHOLOGY VISIT CHARGES	0	0	0
29	MEDICAL SOCIAL SERVICE VISITS	0	0	0
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31	HOME HEALTH AIDE VISITS	0	3	767
32	HOME HEALTH AIDE VISIT CHARGES	0	158	40,269
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	12	2,345
34	OTHER CHARGES	0	317	7,497
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	1,420	215,958
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	1	147
37	TOTAL NUMBER OF OUTLIER EPISODES	0	0	3
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	1,427	275,794

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO:	14-1304		
COMPONENT NO:	14-3453		
COUNTY:	MERCER		
PERIOD:			
FROM	7/ 1/2007		
TO	6/30/2008		
PREPARED	11/23/2008		
WORKSHEET	S-8		

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 1007 NW 3RD STREET

1.01 CITY: ALEDO STATE: IL ZIP CODE: 61231 COUNTY: MERCER

2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN: R

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD 1	DATE 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	DR. ROSCA	K19158
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. SANTIAGO	K25244
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. MAURUS	C44206
9.03	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. M. DICKLIN	S85265
9.04	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. WURZBURGER	K33701
9.05	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. RATTANANONT	K47771

		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DR. ROSCA	1,040.00
10.01	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DR. SANTIAGO	2,076.00

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 FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			730	1800	730	1800	730	1800	730	1800	730	1800		

(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. N

15 PROVIDER NAME: PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.			
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.		N	

HOSPICE IDENTIFICATION DATA

PROVIDER NO:	PERIOD:	PREPARED 11/23/2008
14-1304	FROM 7/ 1/2007	WORKSHEET S-9
HOSPICE NO:	TO 6/30/2008	
14-1593		

HOSPICE 1

PART I - ENROLLMENT DAYS

		TITLE XVIII UNDUPLICATED MEDICARE DAYS 1	TITLE XIX UNDUPLICATED MEDICAID DAYS 2	TITLE XVIII UNDUPLICATED SNF DAYS 3	TITLE XIX UNDUPLICATED NF DAYS 4
1	CONTINUOUS HOME CARE				
2	ROUTINE HOME CARE	1,597			
3	INPATIENT RESPITE CARE	28			
4	GENERAL INPATIENT CARE	56			
5	TOTAL HOSPICE DAYS	1,681			

PART I - ENROLLMENT DAYS (CONTINUED)

		OTHER UNDUPLICATED DAYS 5	TOTAL UNDUPLICATED DAYS 6
1	CONTINUOUS HOME CARE		
2	ROUTINE HOME CARE	185	1,782
3	INPATIENT RESPITE CARE		28
4	GENERAL INPATIENT CARE	93	149
5	TOTAL HOSPICE DAYS	278	1,959

PART II - CENSUS DATA

		TITLE XVIII 1	TITLE XIX 2	TITLE XVIII SNF 3	TITLE XIX NF 4
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	39	1		
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE				
8	AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)	43.10			
9	UNDUPLICATED CENSUS COUNT	39	1		

PART II - CENSUS DATA (CONTINUED)

		OTHER 5	TOTAL 6
6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	14	54
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS CARE HOURS BILLABLE TO MEDICARE		
8	AVERAGE LENGTH OF STAY (LINE 5 DIVIDED BY LINE 6)	19.86	36.28
9	UNDUPLICATED CENSUS COUNT	14	54

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		121,486	121,486	80,304	201,790
3.01	0301	FOUNDATION BLDG				90,600	90,600
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		410,157	410,157	49,301	459,458
5	0500	EMPLOYEE BENEFITS	82,465	994,529	1,076,994		1,076,994
6.01	0610	ADMITTING	94,448	16,804	111,252		111,252
6.02	0650	A&G HOSPITAL ONLY	380,693	261,134	641,827	20,089	661,916
6.03	0660	SHARED ADMIN & GENERAL	309,252	448,337	757,589	285,867	1,043,456
7	0700	MAINTENANCE & REPAIRS	150,504	136,320	286,824		286,824
8	0800	OPERATION OF PLANT		236,239	236,239		236,239
9	0900	LAUNDRY & LINEN SERVICE	16,806	33,985	50,791		50,791
10	1000	HOUSEKEEPING	73,917	38,490	112,407		112,407
11	1100	DIETARY	202,162	225,635	427,797		427,797
12	1200	CAFETERIA					
14	1400	NURSING ADMINISTRATION	95,498	13,704	109,202		109,202
15	1500	CENTRAL SERVICES & SUPPLY	30,894	4,068	34,962		34,962
17	1700	MEDICAL RECORDS & LIBRARY	124,086	28,101	152,187		152,187
18	1800	SOCIAL SERVICE	47,222	4,286	51,508		51,508
20	2000	NONPHYSICIAN ANESTHETISTS		169,220	169,220		169,220
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	838,977	237,199	1,076,176	32,800	1,108,976
36	3600	OTHER LONG TERM CARE	325,481	56,781	382,262		382,262
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	100,425	116,429	216,854		216,854
40	4000	ANESTHESIOLOGY		1,693	1,693		1,693
41	4100	RADIOLOGY-DIAGNOSTIC	412,195	288,703	700,898	206,904	907,802
44	4400	LABORATORY	364,974	569,769	934,743	-33,014	901,729
47	4700	BLOOD STORING, PROCESSING & TRANS.				33,014	33,014
49	4900	RESPIRATORY THERAPY	120,251	31,510	151,761		151,761
50	5000	PHYSICAL THERAPY	236,076	26,909	262,985		262,985
51	5100	OCCUPATIONAL THERAPY		26,919	26,919		26,919
52	5200	SPEECH PATHOLOGY		6,821	6,821		6,821
53	5300	ELECTROCARDIOLOGY		236,182	236,182	-206,904	29,278
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	5600	DRUGS CHARGED TO PATIENTS	104,304	441,647	545,951		545,951
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	364,580	814,877	1,179,457		1,179,457
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTE					
63.50	6310	RURAL HEALTH CLINIC	895,186	446,624	1,341,810	-146,378	1,195,432
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES					
71	7100	HOME HEALTH AGENCY	350,335	152,213	502,548	-71,020	431,528
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		131,109	131,109	-131,109	
90	9000	OTHER CAPITAL RELATED COSTS		209,086	209,086	-209,086	
93	9300	HOSPICE	41,207	52,664	93,871	-1,368	92,503
95		SUBTOTALS	5,761,938	6,989,630	12,751,568	-0-	12,751,568
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES					
100	7950	BOARD OF HEALTH					
100.01	7951	VACANT PHYSICIAN OFFICE					
100.02	7952	MOBILE MEALS					
100.03	7953	KIDNEY CENTER					
101		TOTAL	5,761,938	6,989,630	12,751,568	-0-	12,751,568

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-13,827	187,963
3.01	0301	FOUNDATION BLDG	-32,797	57,803
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-1,973	457,485
5	0500	EMPLOYEE BENEFITS	-21,625	1,055,369
6.01	0610	ADMITTING		111,252
6.02	0650	A&G HOSPITAL ONLY		661,916
6.03	0660	SHARED ADMIN & GENERAL	-57,219	986,237
7	0700	MAINTENANCE & REPAIRS		286,824
8	0800	OPERATION OF PLANT		236,239
9	0900	LAUNDRY & LINEN SERVICE		50,791
10	1000	HOUSEKEEPING		112,407
11	1100	DIETARY	-81,778	346,019
12	1200	CAFETERIA		
14	1400	NURSING ADMINISTRATION		109,202
15	1500	CENTRAL SERVICES & SUPPLY	-1,595	33,367
17	1700	MEDICAL RECORDS & LIBRARY	-5,850	146,337
18	1800	SOCIAL SERVICE		51,508
20	2000	NONPHYSICIAN ANESTHETISTS	-169,220	
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-32,800	1,076,176
36	3600	OTHER LONG TERM CARE		382,262
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		216,854
40	4000	ANESTHESIOLOGY		1,693
41	4100	RADIOLOGY-DIAGNOSTIC		907,802
44	4400	LABORATORY	-14,284	887,445
47	4700	BLOOD STORING, PROCESSING & TRANS.		33,014
49	4900	RESPIRATORY THERAPY	-942	150,819
50	5000	PHYSICAL THERAPY		262,985
51	5100	OCCUPATIONAL THERAPY		26,919
52	5200	SPEECH PATHOLOGY		6,821
53	5300	ELECTROCARDIOLOGY	-14,923	14,355
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	5600	DRUGS CHARGED TO PATIENTS	-216,054	329,897
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-94,768	1,084,689
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTE		
63.50	6310	RURAL HEALTH CLINIC	-17,078	1,178,354
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES		
71	7100	HOME HEALTH AGENCY	-891	430,637
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
93	9300	HOSPICE		92,503
95		SUBTOTALS	-777,624	11,973,944
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		
100	7950	BOARD OF HEALTH		
100.01	7951	VACANT PHYSICIAN OFFICE		
100.02	7952	MOBILE MEALS		
100.03	7953	KIDNEY CENTER		
101		TOTAL	-777,624	11,973,944

COST CENTERS USED IN COST REPORT

I PROVIDER NO: I PERIOD: I PREPARED 11/23/2008
I 14-1304 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET
I I TO 6/30/2008 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	
3.01	FOUNDATION BLDG	0301	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6.01	ADMITTING	0610	NONPATIENT TELEPHONES
6.02	A&G HOSPITAL ONLY	0650	CASHIERING/ACCOUNTS RECEIVABLE
6.03	SHARED ADMIN & GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
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	
18	SOCIAL SERVICE	1800	
20	NONPHYSICIAN ANESTHETISTS	2000	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
36	OTHER LONG TERM CARE	3600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
47	BLOOD STORING, PROCESSING & TRANS.	4700	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
51	OCCUPATIONAL THERAPY	5100	
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTE	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
93	HOSPICE	9300	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
100	BOARD OF HEALTH	7950	OTHER NONREIMBURSABLE COST CENTERS
100.01	VACANT PHYSICIAN OFFICE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	MOBILE MEALS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	KIDNEY CENTER	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 2	LINE NO 3	INCREASE SALARY 4	INCREASE OTHER 5
1	INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		53,500
2			NEW CAP REL COSTS-MVBLE EQUIP	4		21,328
3			SHARED ADMIN & GENERAL	6.03		56,281
4	RECLASS MRI EXPENSE	C	RADIOLOGY-DIAGNOSTIC	41		206,904
5	FOUNDATION	E	FOUNDATION BLDG	3.01		90,600
6						
7						
8						
9	RHC PT ACCT CLERK RECLASS	G	A&G HOSPITAL ONLY	6.02	20,089	
10	RHC GENERAL CLERK RECLASS	H	SHARED ADMIN & GENERAL	6.03	73,126	
11						
12	SYSTEM OPERATOR RECLASS	I	SHARED ADMIN & GENERAL	6.03	15,831	
13						
14	BLOOD EXPENSE RECLASS	J	BLOOD STORING, PROCESSING & TRANS.	47		33,014
15	MALPRACTICE INSURANCE RECLASS	K	SHARED ADMIN & GENERAL	6.03		154,309
16	RHC PHYSICIAN RECLASS	L	ADULTS & PEDIATRICS	25		32,800
36	TOTAL RECLASSIFICATIONS				109,046	648,736

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

	EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	LINE NO	DECREASE SALARY	DECREASE OTHER	A-7 REF
	1		6	7	8	9	10
1	INTEREST EXPENSE	A	INTEREST EXPENSE	88		131,109	9
2							9
3							
4	RECLASS MRI EXPENSE	C	ELECTROCARDIOLOGY	53		206,904	
5	FOUNDATION	E	RURAL HEALTH CLINIC	63.50		54,600	9
6			HOME HEALTH AGENCY	71		21,240	
7			HOSPICE	93		1,080	
8			SHARED ADMIN & GENERAL	6.03		13,680	
9	RHC PT ACCT CLERK RECLASS	G	RURAL HEALTH CLINIC	63.50	20,089		
10	RHC GENERAL CLERK RECLASS	H	RURAL HEALTH CLINIC	63.50	38,889		
11			HOME HEALTH AGENCY	71	34,237		
12	SYSTEM OPERATOR RECLASS	I	HOME HEALTH AGENCY	71	15,543		
13			HOSPICE	93	288		
14	BLOOD EXPENSE RECLASS	J	LABORATORY	44		33,014	
15	MALPRACTICE INSURANCE RECLASS	K	OTHER CAPITAL RELATED COSTS	90		154,309	
16	RHC PHYSICIAN RECLASS	L	RURAL HEALTH CLINIC	63.50		32,800	
36	TOTAL RECLASSIFICATIONS				109,046	648,736	

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

RECLASS CODE: A
EXPLANATION : INTEREST EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	53,500	INTEREST EXPENSE	88	131,109
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	21,328			0
3.00	SHARED ADMIN & GENERAL	6.03	56,281			0
TOTAL RECLASSIFICATIONS FOR CODE A			131,109			131,109

RECLASS CODE: C
EXPLANATION : RECLASS MRI EXPENSE

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	41	206,904	ELECTROCARDIOLOGY	53	206,904
TOTAL RECLASSIFICATIONS FOR CODE C			206,904			206,904

RECLASS CODE: E
EXPLANATION : FOUNDATION

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	FOUNDATION BLDG	3.01	90,600	RURAL HEALTH CLINIC	63.50	54,600
2.00			0	HOME HEALTH AGENCY	71	21,240
3.00			0	HOSPICE	93	1,080
4.00			0	SHARED ADMIN & GENERAL	6.03	13,680
TOTAL RECLASSIFICATIONS FOR CODE E			90,600			90,600

RECLASS CODE: G
EXPLANATION : RHC PT ACCT CLERK RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	A&G HOSPITAL ONLY	6.02	20,089	RURAL HEALTH CLINIC	63.50	20,089
TOTAL RECLASSIFICATIONS FOR CODE G			20,089			20,089

RECLASS CODE: H
EXPLANATION : RHC GENERAL CLERK RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	SHARED ADMIN & GENERAL	6.03	73,126	RURAL HEALTH CLINIC	63.50	38,889
2.00			0	HOME HEALTH AGENCY	71	34,237
TOTAL RECLASSIFICATIONS FOR CODE H			73,126			73,126

RECLASS CODE: I
EXPLANATION : SYSTEM OPERATOR RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	SHARED ADMIN & GENERAL	6.03	15,831	HOME HEALTH AGENCY	71	15,543
2.00			0	HOSPICE	93	288
TOTAL RECLASSIFICATIONS FOR CODE I			15,831			15,831

RECLASS CODE: J
EXPLANATION : BLOOD EXPENSE RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	BLOOD STORING, PROCESSING & TR	47	33,014	LABORATORY	44	33,014
TOTAL RECLASSIFICATIONS FOR CODE J			33,014			33,014

RECLASS CODE: K
EXPLANATION : MALPRACTICE INSURANCE RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	SHARED ADMIN & GENERAL	6.03	154,309	OTHER CAPITAL RELATED COSTS	90	154,309
TOTAL RECLASSIFICATIONS FOR CODE K			154,309			154,309

RECLASS CODE: L
EXPLANATION : RHC PHYSICIAN RECLASS

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADULTS & PEDIATRICS	25	32,800	RURAL HEALTH CLINIC	63.50	32,800
TOTAL RECLASSIFICATIONS FOR CODE L			32,800			32,800

Health Financial Systems MCRIF32 FOR MERCER COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS

PROVIDER NO: 14-1304

PERIOD: FROM 7/ 1/2007 TO 6/30/2008

PREPARED 11/23/2008

WORKSHEET A-7

PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	43,583					43,583	
2	LAND IMPROVEMENTS	85,552				76,263	9,289	
3	BUILDINGS & FIXTURE	4,252,042				422,473	3,829,569	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	5,167,773	923,451		923,451	2,039,364	4,051,860	
7	SUBTOTAL	9,548,950	923,451		923,451	2,538,100	7,934,301	
8	RECONCILING ITEMS	542,215	550,187		550,187	472,031	620,371	
9	TOTAL	9,006,735	373,264		373,264	2,066,069	7,313,930	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	3,882,441		3,882,441	.489324	26,804			26,804
3 01	FOUNDATION BLDG								
4	NEW CAP REL COSTS-MV	4,051,860		4,051,860	.510676	27,973			27,973
5	TOTAL	7,934,301		7,934,301	1.000000	54,777			54,777

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	161,159			26,804			187,963
3 01	FOUNDATION BLDG	57,803						57,803
4	NEW CAP REL COSTS-MV	429,512			27,973			457,485
5	TOTAL	648,474			54,777			703,251

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	121,486						121,486
3 01	FOUNDATION BLDG							
4	NEW CAP REL COSTS-MV	410,157						410,157
5	TOTAL	531,643						531,643

* All lines numbers except line 5 are to be consistent with Workhseet 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: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A-8

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
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			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES					
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-142,491			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-32,797			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS					
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS					
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		OCCUPATIONAL THERAPY	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	SERVICE CHARGE REVENUE	B	-6,093	SHARED ADMIN & GENERAL	6.03	
38	CAFETERIA REV	B	-49,807	DIETARY	11	
39	VENDING SUPPLIES	B	-11,983	DIETARY	11	
40	MISC REV - DIET	B	-7,837	DIETARY	11	
41	VENDING REV	B	-12,151	DIETARY	11	
41.01	MISC REV - SUPPLIES	B	-1,595	CENTRAL SERVICES & SUPPLY	15	
41.02	MISC REV - MED REC	B	-5,850	MEDICAL RECORDS & LIBRARY	17	
41.03	EMPLOYEE DRUG REVENUE	B	-3	DRUGS CHARGED TO PATIENTS	56	
41.04	MISC REV - LAB	B	-13,855	LABORATORY	44	
41.05	MISC REV - CARDIO	B	-942	RESPIRATORY THERAPY	49	
41.06	MISC REV - PHARM	B	-216,051	DRUGS CHARGED TO PATIENTS	56	
41.07	VENDOR REBATES	B	-23,145	SHARED ADMIN & GENERAL	6.03	
41.08	RENTAL REVENUE	B	-10,590	RURAL HEALTH CLINIC	63.50	
41.09	MISC REV - HHA	B	-670	HOME HEALTH AGENCY	71	
41.10	INTEREST INCOME	B	-13,827	NEW CAP REL COSTS-BLDG &	3	9
41.11	MISC INCOME - OTHER REV	B	-10,074	SHARED ADMIN & GENERAL	6.03	
41.12	OFFSET EX UNSHELT BOND SINK	A	-1,874	NEW CAP REL COSTS-MVBLE E	4	9
41.13	PATIENT PHONES EQUIP	A	-99	NEW CAP REL COSTS-MVBLE E	4	9
41.14	PATIENT PHONES SALARY	A	-357	SHARED ADMIN & GENERAL	6.03	
41.15	PATIENT PHONES BENEFITS	A	-102	EMPLOYEE BENEFITS	5	
41.16	PATIENT PHONES COST	A	-1,564	SHARED ADMIN & GENERAL	6.03	
41.17	LOBBY EXPENSE	A	-6,386	SHARED ADMIN & GENERAL	6.03	
42	CRNA FEES	A	-169,220	NONPHYSICIAN ANESTHETISTS	20	
43	COUNTRY CLUB DUES	A	-1,100	SHARED ADMIN & GENERAL	6.03	
44	ADVERTISING	A	-6,488	RURAL HEALTH CLINIC	63.50	
45	ADVERTISING	A	-21,523	EMPLOYEE BENEFITS	5	
46	ADVERTISING	A	-429	LABORATORY	44	
47	ADVERTISING	A	-221	HOME HEALTH AGENCY	71	
48	PHYSICIAN PRACTICE AMORTIZATION	A	-8,500	SHARED ADMIN & GENERAL	6.03	
49						
50	TOTAL (SUM OF LINES 1 THRU 49)		-777,624			

(1) Description - all chapter references in this columnpertain 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

Health Financial Systems MCRIF32 FOR MERCER COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | PROVIDER NO: 14-1304 | PERIOD: FROM 7/ 1/2007 TO 6/30/2008 | PREPARED 11/23/2008 | WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
1	3 1 FOUNDATION BLDG	FOUNDATION	57,803	90,600	-32,797	9
2						
3						
4						
5	TOTALS		57,803	90,600	-32,797	

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

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

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

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	A	MERCER COUNTY HOSPITAL	100.00	MERCER FOUNDATION FOR HTL	0.00	NOT-FOR-PROFIT
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

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

A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.

B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.

C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.

D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.

E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.

F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.

G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

Health Financial Systems MCRIF32 FOR MERCER COUNTY HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	61	EMERGENCY	616,764	94,768	521,996				
2	53	EKG	14,473	14,473					
3	53	EEG	450	450					
4	25	ADULTS & PEDIATRICS	32,800	32,800					
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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25									
26									
27									
28									
29									
30									
101		TOTAL	664,487	142,491	521,996				

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUSTMENT 18
1	61	EMERGENCY							94,768
2	53	EKG							14,473
3	53	EEG							450
4	25	ADULTS & PEDIATRICS							32,800
5									
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28									
29									
30									
101		TOTAL							142,491

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

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	260
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.63
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	3.63

		SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED		566.00			
10	AHSEA (SEE INSTRUCTIONS)		64.22			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	32.11	32.11			
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)					
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)					
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)					
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	36,349
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	36,349
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	36,349

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	64.22
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	50,092
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	50,092

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

STANDARD TRAVEL ALLOWANCE

24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	8,349
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	8,349
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	944
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	9,293

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

OCCUPATIONAL THERAPY

33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28)	9,293
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)	
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)	

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23)	50,092
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35)	9,293
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)	
60	OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)	
61	EQUIPMENT COST (SEE INSTRUCTIONS)	
62	SUPPLIES (SEE INSTRUCTIONS)	
63	TOTAL ALLOWANCE (SUM OF LINES 57-62)	59,385
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS)	26,401

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

I PROVIDER NO: 14-1304 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008 I PREPARED 11/23/2008 I WORKSHEET A-8-4 I PARTS I - VII

OCCUPATIONAL THERAPY

65	EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)	

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

66	COST OF OUTSIDE SUPPLIER SERVICES - (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	26,401
66.01	COST OF OUTSIDE SUPPLIER SERVICES - CORF I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
66.31	COST OF OUTSIDE SUPPLIER SERVICES - HHA I (SEE INSTRUCTIONS)(FROM YOUR RECORDS)	
67	TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64)	26,401
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67)	1.000000
68.01	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)	
68.31	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)	
69	EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.01	EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
69.31	EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)	
70	TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)	