

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	14-1311	I	FROM 7/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/21/2008 TIME 10:51

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:  
FAIRFIELD MEMORIAL HOSPITAL 14-1311  
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.

\_\_\_\_\_  
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	745,069	247,643	0	
5	HOSPITAL-BASED SNF	0	0	0	0	
6	HOSPITAL-BASED NF	0	0	0	0	
7	HOSPITAL-BASED HHA	0	0	0	0	
100	TOTAL	0	745,069	247,643	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 & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-2
I I TO 6/30/2008 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 303 NW 11TH ST
1.01 CITY: FAIRFIELD

P.O. BOX:
STATE: IL ZIP CODE: 62837- COUNTY: WAYNE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

Table with columns: COMPONENT, COMPONENT NAME, PROVIDER NO., NPI NUMBER, DATE CERTIFIED, PAYMENT SYSTEM (P, T, O OR N). Rows include HOSPITAL, HOSPITAL-BASED SNF, HOSPITAL-BASED NF, HOSPITAL-BASED HHA.

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

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? N

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

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

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

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

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

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.

28 IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02

28.01 IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)

	1	2	3	4
28.02	100	0.8320	0.8335	
	256.96	2	14	99914

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

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	1.00%	Y
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) 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 V XVIII XIX

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 1 2 3  
 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? N  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? 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
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: 0  
 PAID LOSSES: 0  
 AND/OR SELF INSURANCE: 0  
 54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

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

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

COMPONENT	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	I/P DAYS / TITLE XVIII	O/P VISITS / NOT LTCH N/A	TRIPS TOTAL TITLE XIX
1 ADULTS & PEDIATRICS	1	21	2.01	3		4.01	5
2 HMO		7,686	85,800.00			2,098	507
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	21	7,686	85,800.00			2,098	507
6 INTENSIVE CARE UNIT	4	1,464	9,792.00			282	
11 NURSERY							
12 TOTAL	25	9,150	95,592.00			2,380	507
13 RPCH VISITS							
15 SKILLED NURSING FACILITY	30	10,980				2,627	
16 NURSING FACILITY	104	38,964					23,231
18 HOME HEALTH AGENCY							87
25 TOTAL	159					4,419	
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED	I/P DAYS / OBSERVATION BEDS NOT ADMITTED	O/P VISITS / TOTAL ALL PATS	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED	NOT ADMITTED	--- INTERNS & RES. FTES -- TOTAL	LESS I&R REPL NON-PHYS ANES
1 ADULTS & PEDIATRICS	5.01	5.02	6	6.01	6.02	7	8
2 HMO			3,321				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			3,321				
6 INTENSIVE CARE UNIT			383				
11 NURSERY			297				
12 TOTAL			4,001				
13 RPCH VISITS							
15 SKILLED NURSING FACILITY			6,579				
16 NURSING FACILITY			30,698				
18 HOME HEALTH AGENCY			5,629				
25 TOTAL			531		531		
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
1 ADULTS & PEDIATRICS	9	10	11	12	13	14	15
2 HMO					443	248	1,201
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
6 INTENSIVE CARE UNIT							
11 NURSERY							
12 TOTAL		163.01			443	248	1,201
13 RPCH VISITS							
15 SKILLED NURSING FACILITY		18.32					
16 NURSING FACILITY		80.71					
18 HOME HEALTH AGENCY		6.52					
25 TOTAL		268.56					
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 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-3  
 I I TO 6/30/2008 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
1 SALARIES						
2 TOTAL SALARY	10,004,645		10,004,645	564,270.00	17.73	
3 NON-PHYSICIAN ANESTHETIST PART A						
4 NON-PHYSICIAN ANESTHETIST PART B						
5 PHYSICIAN - PART A						
4.01 TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)						
6 PHYSICIAN - PART B						
5.01 NON-PHYSICIAN - PART B						
7 INTERNS & RESIDENTS (APPRVD)						
6.01 CONTRACT SERVICES, I&R						
8 HOME OFFICE PERSONNEL						
8 SNF	551,394		551,394	36,055.00	15.29	
8.01 EXCLUDED AREA SALARIES	2,215,535		2,215,535	203,678.00	10.88	
9 OTHER WAGES & RELATED COSTS						
9.01 CONTRACT LABOR:						
9.01 PHARMACY SERVICES UNDER CONTRACT						
9.02 LABORATORY SERVICES UNDER CONTRACT						
9.03 MANAGEMENT & ADMINISTRATIVE UNDER CONTRACT						
10 CONTRACT LABOR: PHYS PART A						
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)						
13 WAGE RELATED COSTS						
14 WAGE-RELATED COSTS (CORE)	1,061,891		1,061,891			CMS 339
15 WAGE-RELATED COSTS (OTHER)						CMS 339
16 EXCLUDED AREAS	510,944		510,944			CMS 339
17 NON-PHYS ANESTHETIST PART A						CMS 339
18 NON-PHYS ANESTHETIST PART B						CMS 339
19 PHYSICIAN PART A						CMS 339
18.01 PART A TEACHING PHYSICIANS						CMS 339
20 PHYSICIAN PART B						CMS 339
19.01 WAGE-RELATD COSTS (RHC/FQHC)						CMS 339
21 INTERNS & RESIDENTS (APPRVD)						CMS 339
22 OVERHEAD COSTS - DIRECT SALARIES						
23 EMPLOYEE BENEFITS	57,076		57,076	1,993.00	28.64	
24 ADMINISTRATIVE & GENERAL	776,190		776,190	34,618.00	22.42	
22.01 A & G UNDER CONTRACT						
25 MAINTENANCE & REPAIRS	194,742		194,742	12,414.00	15.69	
26 OPERATION OF PLANT						
27 LAUNDRY & LINEN SERVICE	11,609		11,609	1,758.00	6.60	
28 HOUSEKEEPING	205,315		205,315	25,148.00	8.16	
26.01 HOUSEKEEPING UNDER CONTRACT						
29 DIETARY	216,862	-43,345	173,517	6,559.00	26.45	
27.01 DIETARY UNDER CONTRACT						
30 CAFETERIA		43,345	43,345	12,862.00	3.37	
31 MAINTENANCE OF PERSONNEL						
32 NURSING ADMINISTRATION	118,191		118,191	4,332.00	27.28	
33 CENTRAL SERVICE AND SUPPLY						
34 PHARMACY						
35 MEDICAL RECORDS & MEDICAL RECORDS LIBRARY	195,867		195,867	16,399.00	11.94	
36 SOCIAL SERVICE	68,616		68,616	4,365.00	15.72	
37 OTHER GENERAL SERVICE						
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	10,004,645		10,004,645	564,270.00	17.73	
2 EXCLUDED AREA SALARIES	2,766,929		2,766,929	239,733.00	11.54	
3 SUBTOTAL SALARIES	7,237,716		7,237,716	324,537.00	22.30	
4 SUBTOTAL OTHER WAGES & RELATED COSTS						
5 SUBTOTAL WAGE-RELATED COSTS	1,061,891		1,061,891		14.67	
6 TOTAL	8,299,607		8,299,607	324,537.00	25.57	
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	1,844,468		1,844,468	120,448.00	15.31	

HOSPITAL-BASED HOME HEALTH AGENCY  
 STATISTICAL DATA  
 HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-4  
 I HHA NO: I TO 6/30/2008 I  
 I 14-7612 I  
 COUNTY: WAYNE

HHA 1

	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1 HOME HEALTH AIDE HOURS	0	0	0	0
2 UNDUPLICATED CENSUS COUNT		168.00		
	TOTAL 5			
1 HOME HEALTH AIDE HOURS	0			
2 UNDUPLICATED CENSUS COUNT	214.00			
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				
6 DIRECTING NURSING SERVICE				
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				
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		LUPA	PEP ONLY
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	EPISODES 3	EPISODES 4
21 SKILLED NURSING VISITS	2,388	1,023	27	42
22 SKILLED NURSING VISIT CHARGES	262,680	112,530	2,970	4,620
23 PHYSICAL THERAPY VISITS	777	0	12	1
24 PHYSICAL THERAPY VISIT CHARGES	85,470	0	1,320	110
25 OCCUPATIONAL THERAPY VISITS	83	0	1	0
26 OCCUPATIONAL THERAPY VISIT CHARGES	9,130	0	110	0
27 SPEECH PATHOLOGY VISITS	18	4	0	0
28 SPEECH PATHOLOGY VISIT CHARGES	2,070	460	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	43	0	0	0
32 HOME HEALTH AIDE VISIT CHARGES	2,666	0	0	0
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	3,309	1,027	40	43
34 OTHER CHARGES	30,731	12,714	215	1,153
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	392,747	125,704	4,615	5,883
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	215	0	15	3
37 TOTAL NUMBER OF OUTLIER EPISODES	0	18	0	0
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	12,711	5,309	0	26

HOSPITAL-BASED HOME HEALTH AGENCY  
 STATISTICAL DATA  
 HOME HEALTH AGENCY STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-4  
 I HHA NO: I TO 6/30/2008 I  
 I 14-7612 I  
 COUNTY: WAYNE

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	0	3,480
22 SKILLED NURSING VISIT CHARGES	0	0	382,800
23 PHYSICAL THERAPY VISITS	0	0	790
24 PHYSICAL THERAPY VISIT CHARGES	0	0	86,900
25 OCCUPATIONAL THERAPY VISITS	0	0	84
26 OCCUPATIONAL THERAPY VISIT CHARGES	0	0	9,240
27 SPEECH PATHOLOGY VISITS	0	0	22
28 SPEECH PATHOLOGY VISIT CHARGES	0	0	2,530
29 MEDICAL SOCIAL SERVICE VISITS	0	0	0
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31 HOME HEALTH AIDE VISITS	0	0	43
32 HOME HEALTH AIDE VISIT CHARGES	0	0	2,666
33 TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	4,419
34 OTHER CHARGES	0	0	44,813
35 TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	528,949
36 TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	233
37 TOTAL NUMBER OF OUTLIER EPISODES	0	0	18
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	18,046

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	4.02	4.03
1	2	3	3.01	4	4.01	4.02		4.03
1	RUC							
2	RUB							
3	RUA		46					
3 .01	RUX							
3 .02	RUL							
4	RVC							
5	RVB							
6	RVA		69					
6 .01	RVX							
6 .02	RVL		7					
7	RHC		151					
8	RHB		531					
9	RHA		205					
9 .01	RHX							
9 .02	RHL							
10	RMC		105					
11	RMB		327					
12	RMA		137					
12 .01	RMX		235					
12 .02	RML		467					
13	RLB							
14	RLA							
14 .01	RLX							
15	SE3		45					
16	SE2		192					
17	SE1							
18	SSC							
19	SSB		9					
20	SSA		73					
21	CC2							
22	CC1							
23	CB2							
24	CB1							
25	CA2							
26	CA1		28					
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	AAA							
46	TOTAL		2,627					

(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 : 256.96  
 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 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I

	GROUP(1)	M3PI	HIGH COST(2)	SWING BED SNF	TOTAL
		REVENUE CODE	RUGs DAYS	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				
9	.01 RHX				
9	.02 RHL				
10	RMC				
11	RMB				
12	RMA				
12	.01 RMX				
12	.02 RML				
13	RLB				
14	RLA				
14	.01 RLX				
15	SE3				
16	SE2				
17	SE1				
18	SSC				
19	SSB				
20	SSA				
21	CC2				
22	CC1				
23	CB2				
24	CB1				
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	AAA				
46	TOTAL				

(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 : 256.96  
 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 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I NOT A CMS WORKSHEET  
SERVICES THROUGH 12/31/2005

GROUP(1) 1	M3PI REVENUE CODE	SERVICES BASE RATE 3a	PRIOR TO RATE 3	OCTOBER 1ST DAYS 3.01	SERVICES BASE RATE 4a	ON OR AFTER RATE 4	OCTOBER 1ST DAYS 4.01
1	RUC	458.21			478.65		
2	RUB	423.86			442.78	442.78	46
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	345.27	4	360.68	360.68	65
6	RVA	313.30			327.29		
6 .01	RVX	398.56			416.34	416.34	7
6 .02	RVL	373.70			390.37		
7	RHC	310.08	310.08	72	323.91	323.91	79
8	RHB	297.06	297.06	144	310.31	310.31	387
9	RHA	276.93	276.93	95	289.28	289.28	110
9 .01	RHX	333.76			348.65		
9 .02	RHL	327.84			342.47		
10	RMC	283.49	283.49	38	296.13	296.13	67
11	RMB	276.38	276.38	135	288.72	288.72	192
12	RMA	270.46	270.46	39	282.53	282.53	98
12 .01	RMX	375.84	375.84	20	392.62	392.62	215
12 .02	RML	346.24	346.24	85	361.69	361.69	382
13	RLB	245.70			256.66		
14	RLA	211.37			220.79		
14 .01	RLX	265.84			277.69		
15	SE3	297.80	297.80	18	311.09	311.09	27
16	SE2	253.99	253.99	52	265.33	265.33	140
17	SE1	226.75			236.87		
18	SSC	223.20			233.17		
19	SSB	211.36	211.36	9	220.79		
20	SSA	207.81	207.81	32	217.09	217.09	41
21	CC2	222.01			231.93		
22	CC1	203.07			212.13		
23	CB2	193.60			202.24		
24	CB1	185.31			193.58		
25	CA2	184.12			192.34		
26	CA1	172.28	172.28	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	AAA	136.76			142.87		
46	TOTAL			771			1,856

(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 : 256.96  
 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 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I NOT A CMS WORKSHEET  
SERVICES THROUGH 12/31/2005

GROUP(1)	M3PI REVENUE CODE	A I D S		DIAGNOSIS	CODE	042	SWING	TOTAL
		SERV PRIOR TO	OCT. 1ST	SERV ON/AFTER	OCT. 1ST	BED SNF		
1	2	RATE	DAYS	RATE	DAYS	DAYS		5
1	RUC	1,044.72	4.02	1,091.32	4.04	4.05	4.06	5
2	RUB	966.40		1,009.54				20,368
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				24,825
6	RVA	714.32		746.22				
6 .01	RVX	908.72		949.26				2,914
6 .02	RVL	852.04		890.04				
7	RHC	706.98		738.51				47,915
8	RHB	677.30		707.51				162,867
9	RHA	631.40		659.56				58,129
9 .01	RHX	760.97		794.92				
9 .02	RHL	747.48		780.83				
10	RMC	646.36		675.18				30,614
11	RMB	630.15		658.28				92,745
12	RMA	616.65		644.17				38,236
12 .01	RMX	856.92		895.17				91,930
12 .02	RML	789.43		824.65				167,596
13	RLB	560.20		585.18				
14	RLA	481.92		503.40				
14 .01	RLX	606.12		633.13				
15	SE3	678.98		709.29				13,759
16	SE2	579.10		604.95				50,353
17	SE1	516.99		540.06				
18	SSC	508.90		531.63				
19	SSB	481.90		503.40				1,902
20	SSA	473.81		494.97				15,551
21	CC2	506.18		528.80				
22	CC1	463.00		483.66				
23	CB2	441.41		461.11				
24	CB1	422.51		441.36				
25	CA2	419.79		438.54				
26	CA1	392.80		410.33				4,824
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	AAA	311.81		325.74				
46	TOTAL							824,528

(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 : 256.96  
 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.  
 [x] Transfer total to settlement worksheet.

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET S-10  
 I I TO 6/30/2008 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	Other methods of write-offs (speci	
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	<del>IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?</del>	
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	28,761
17.01	GROSS MEDICAID REVENUES	1,996,785
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	2,025,546
UNCOMPENSATED CARE COST		
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.463318
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	



RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I  
I 14-1311 I  
I I

I PERIOD: I PREPARED 11/21/2008  
I FROM 7/ 1/2007 I WORKSHEET A  
I TO 6/30/2008 I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		590,893	590,893		590,893
4	0400 NEW CAP REL COSTS-MVBLE EQUIP				393,189	393,189
5	0500 EMPLOYEE BENEFITS	57,076	1,904,169	1,961,245		1,961,245
6	0600 ADMINISTRATIVE & GENERAL	776,190	1,918,979	2,695,169	-3,077	2,692,092
7	0700 MAINTENANCE & REPAIRS	194,742	360,252	554,994	-540	554,454
8	0800 OPERATION OF PLANT		399,905	399,905		399,905
9	0900 LAUNDRY & LINEN SERVICE	11,609	137,744	149,353		149,353
10	1000 HOUSEKEEPING	205,315	68,032	273,347		273,347
11	1100 DIETARY	216,862	295,665	512,527	-104,096	408,431
12	1200 CAFETERIA				102,440	102,440
14	1400 NURSING ADMINISTRATION	118,191	8,893	127,084		127,084
17	1700 MEDICAL RECORDS & LIBRARY	195,867	32,862	228,729	-1,170	227,559
18	1800 SOCIAL SERVICE	68,616	4,553	73,169		73,169
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,393,913	84,507	1,478,420	-117,413	1,361,007
26	2600 INTENSIVE CARE UNIT	187,348	11,591	198,939		198,939
33	3300 NURSERY				89,629	89,629
34	3400 SKILLED NURSING FACILITY	551,394	43,776	595,170	-4,201	590,969
35	3500 NURSING FACILITY	1,936,210	1,454,430	3,390,640		3,390,640
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	1,015,814	357,247	1,373,061		1,373,061
39	3900 DELIVERY ROOM & LABOR ROOM				26,859	26,859
41	4100 RADIOLOGY-DIAGNOSTIC	409,827	1,135,288	1,545,115	-232,851	1,312,264
44	4400 LABORATORY	665,262	940,845	1,606,107	-86,487	1,519,620
49	4900 RESPIRATORY THERAPY	136,535	107,938	244,473	-78,838	165,635
50	5000 PHYSICAL THERAPY	704,947	64,821	769,768	-2,636	767,132
53	5300 ELECTROCARDIOLOGY				71,738	71,738
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	42,754	682,924	725,678	-1,621	724,057
56	5600 DRUGS CHARGED TO PATIENTS	205,191	1,020,986	1,226,177		1,226,177
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	155,437	120,896	276,333		276,333
	OUTPAT SERVICE COST CNTRS					
61	6100 EMERGENCY	476,220	1,326,424	1,802,644	-2,859	1,799,785
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
	OTHER REIMBURS COST CNTRS					
71	7100 HOME HEALTH AGENCY	279,325	77,911	357,236	-1,621	355,615
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		126,359	126,359	-46,445	79,914
95	SUBTOTALS	10,004,645	13,277,890	23,282,535	-0-	23,282,535
	NONREIMBURS COST CENTERS					
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
101	TOTAL	10,004,645	13,277,890	23,282,535	-0-	23,282,535

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I  
I 14-1311 I  
I I

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

I PREPARED 11/21/2008  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
		6	7
	GENERAL SERVICE COST CNTR		
3	0300 NEW CAP REL COSTS-BLDG & FIXT	-94,049	496,844
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		393,189
5	0500 EMPLOYEE BENEFITS		1,961,245
6	0600 ADMINISTRATIVE & GENERAL	-333,733	2,358,359
7	0700 MAINTENANCE & REPAIRS		554,454
8	0800 OPERATION OF PLANT		399,905
9	0900 LAUNDRY & LINEN SERVICE		149,353
10	1000 HOUSEKEEPING		273,347
11	1100 DIETARY		408,431
12	1200 CAFETERIA	-110,232	-7,792
14	1400 NURSING ADMINISTRATION		127,084
17	1700 MEDICAL RECORDS & LIBRARY	-4,420	223,139
18	1800 SOCIAL SERVICE		73,169
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS	-220	1,360,787
26	2600 INTENSIVE CARE UNIT		198,939
33	3300 NURSERY		89,629
34	3400 SKILLED NURSING FACILITY		590,969
35	3500 NURSING FACILITY		3,390,640
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-43,820	1,329,241
39	3900 DELIVERY ROOM & LABOR ROOM		26,859
41	4100 RADIOLOGY-DIAGNOSTIC	2,104	1,314,368
44	4400 LABORATORY		1,519,620
49	4900 RESPIRATORY THERAPY		165,635
50	5000 PHYSICAL THERAPY		767,132
53	5300 ELECTROCARDIOLOGY	-38,697	33,041
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		724,057
56	5600 DRUGS CHARGED TO PATIENTS		1,226,177
59	3550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		276,333
	OUTPAT SERVICE COST CNTRS		
61	6100 EMERGENCY	-865,430	934,355
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
	OTHER REIMBURS COST CNTRS		
71	7100 HOME HEALTH AGENCY		355,615
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE	-79,914	-0-
95	SUBTOTALS	-1,568,411	21,714,124
	NONREIMBURS COST CENTERS		
96	9600 GIFT, FLOWER, COFFEE SHOP & CANTEEN		
101	TOTAL	-1,568,411	21,714,124

Health Financial Systems MCRIF32  
 COST CENTERS USED IN COST REPORT

FOR FAIRFIELD MEMORIAL HOSPITAL

IN LIEU OF FORM CMS-2552-96(9/1996)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 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	
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	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141311	FROM 7/ 1/2007	11/21/2008
	TO 6/30/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	INCREASE		SALARY	OTHER
			LINE NO			
1 CAFETERIA	A	CAFETERIA	12		43,345	59,095
2 L&D/NURSERY	B	NURSERY	33		89,629	
3		DELIVERY ROOM & LABOR ROOM	39		26,859	
4 EKG	C	ELECTROCARDIOLOGY	53		33,041	38,697
5 RENTAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4			393,189
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18 INTEREST	E	ADMINISTRATIVE & GENERAL	6			46,445
36 TOTAL RECLASSIFICATIONS					192,874	537,426

(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: 141311	PERIOD: FROM 7/ 1/2007 TO 6/30/2008	PREPARED 11/21/2008 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE		SALARY	OTHER	A-7 REF
			LINE NO	7			
1 CAFETERIA		6			8	9	10
2 L&D/NURSERY	A	DIETARY	11		43,345	59,095	
3	B	ADULTS & PEDIATRICS	25		116,488		
4 EKG	C	RESPIRATORY THERAPY	49		33,041	38,697	
5 RENTAL	D	ADMINISTRATIVE & GENERAL	6			49,522	10
6		MAINTENANCE & REPAIRS	7			540	
7		DIETARY	11			1,656	
8		MEDICAL RECORDS & LIBRARY	17			1,170	
9		ADULTS & PEDIATRICS	25			925	
10		SKILLED NURSING FACILITY	34			4,201	
11		RADIOLOGY-DIAGNOSTIC	41			232,851	
12		LABORATORY	44			86,487	
13		RESPIRATORY THERAPY	49			7,100	
14		PHYSICAL THERAPY	50			2,636	
15		MEDICAL SUPPLIES CHARGED TO PATIENTS	55			1,621	
16		EMERGENCY	61			2,859	
17		HOME HEALTH AGENCY	71			1,621	
18 INTEREST	E	INTEREST EXPENSE	88			46,445	
36 TOTAL RECLASSIFICATIONS					192,874	537,426	

(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
141311	FROM 7/ 1/2007	11/21/2008
	TO 6/30/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : CAFETERIA

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	102,440	DIETARY	11	102,440	
TOTAL RECLASSIFICATIONS FOR CODE A			102,440				102,440

RECLASS CODE: B  
EXPLANATION : L&D/NURSERY

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NURSERY	33	89,629	ADULTS & PEDIATRICS	25	116,488	
2.00	DELIVERY ROOM & LABOR ROOM	39	26,859			0	
TOTAL RECLASSIFICATIONS FOR CODE B			116,488				116,488

RECLASS CODE: C  
EXPLANATION : EKG

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ELECTROCARDIOLOGY	53	71,738	RESPIRATORY THERAPY	49	71,738	
TOTAL RECLASSIFICATIONS FOR CODE C			71,738				71,738

RECLASS CODE: D  
EXPLANATION : RENTAL

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	393,189	ADMINISTRATIVE & GENERAL	6	49,522	
2.00			0	MAINTENANCE & REPAIRS	7	540	
3.00			0	DIETARY	11	1,656	
4.00			0	MEDICAL RECORDS & LIBRARY	17	1,170	
5.00			0	ADULTS & PEDIATRICS	25	925	
6.00			0	SKILLED NURSING FACILITY	34	4,201	
7.00			0	RADIOLOGY-DIAGNOSTIC	41	232,851	
8.00			0	LABORATORY	44	86,487	
9.00			0	RESPIRATORY THERAPY	49	7,100	
10.00			0	PHYSICAL THERAPY	50	2,636	
11.00			0	MEDICAL SUPPLIES CHARGED TO PA	55	1,621	
12.00			0	EMERGENCY	61	2,859	
13.00			0	HOME HEALTH AGENCY	71	1,621	
TOTAL RECLASSIFICATIONS FOR CODE D			393,189				393,189

RECLASS CODE: E  
EXPLANATION : INTEREST

INCREASE				DECREASE			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	ADMINISTRATIVE & GENERAL	6	46,445	INTEREST EXPENSE	88	46,445	
TOTAL RECLASSIFICATIONS FOR CODE E			46,445				46,445

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		
		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	ACQUISITIONS		TOTAL	DISPOSALS	ENDING	FULLY
		BALANCES	PURCHASES	DONATION		AND		
		1	2	3	4	5	6	7
1	LAND	175,762	25,160		25,160		200,922	
2	LAND IMPROVEMENTS	277,229	45,303		45,303		322,532	
3	BUILDINGS & FIXTURE	11,409,129	234,026		234,026		11,643,155	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	664,335	32,160		32,160		696,495	
6	MOVABLE EQUIPMENT	6,722,831	120,222		120,222		6,843,053	
7	SUBTOTAL	19,249,286	456,871		456,871		19,706,157	
8	RECONCILING ITEMS							
9	TOTAL	19,249,286	456,871		456,871		19,706,157	

PART III - RECONCILIATION OF CAPITAL COST CENTERS  
 DESCRIPTION

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	12,256,249		12,256,249	.653740				
4	NEW CAP REL COSTS-MV	6,491,648		6,491,648	.346260				
5	TOTAL	18,747,897		18,747,897	1.000000				

DESCRIPTION

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	558,204	-61,360					496,844
4	NEW CAP REL COSTS-MV		393,189					393,189
5	TOTAL	558,204	331,829					890,033

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

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	590,893						590,893
4	NEW CAP REL COSTS-MV							
5	TOTAL	590,893						590,893

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO:  
I 14-1311  
I

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

I PREPARED 11/21/2008  
I WORKSHEET A-8

DESCRIPTION (1)	(2)		EXPENSE CLASSIFICATION ON		WKST. A-7 REF. 5
	BASIS/CODE 1	AMOUNT 2	WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 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			NEW CAP REL COSTS-BLDG &	3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER	B	-79,914	INTEREST EXPENSE	88	
6 TRADE, QUANTITY AND TIME DISCOUNTS					
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES	A	-4,455	ADMINISTRATIVE & GENERAL	6	
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-947,947			
13 SALE OF SCRAP, WASTE, ETC.					
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1	2,104			
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-110,232	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS					
18 SALE OF MED AND SURG SUPPLIES					
19 SALE OF DRUGS TO OTHER THAN PATIENTS					
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-4,420	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			**COST CENTER DELETED**	20	
34 PHYSICIANS' ASSISTANT					
35 ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36 ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37 OFFICE SPACE	B	-61,360	NEW CAP REL COSTS-BLDG &	3	10
38 BABY PICS	B	-117	ADMINISTRATIVE & GENERAL	6	
39					
40 PRENATAL CLASS	B	-220	ADULTS & PEDIATRICS	25	
41 RINARD & WEBER	A	-32,689	NEW CAP REL COSTS-BLDG &	3	9
42 RECRUITING	A	-182,420	ADMINISTRATIVE & GENERAL	6	
43 ADVERTISING	A	-146,741	ADMINISTRATIVE & GENERAL	6	
44					
45					
46 OTHER ADJUSTMENTS (SPECIFY)					
47 OTHER ADJUSTMENTS (SPECIFY)					
48 OTHER ADJUSTMENTS (SPECIFY)					
49 OTHER ADJUSTMENTS (SPECIFY)					
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,568,411			

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	41	RADIOLOGY-DIAGNOSTIC	MRI	217,374	215,270	2,104
2						
3						
4						
5	TOTALS			217,374	215,270	2,104

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

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

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

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	G	DIAGNOSTIC SHARED SERVICE		15.00	0.00
2				0.00	0.00
3				0.00	0.00
4				0.00	0.00
5				0.00	0.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I  
I 14-1311  
I

I PERIOD: I PREPARED 11/21/2008  
I FROM 7/ 1/2007 I WORKSHEET A-8-2  
I TO 6/30/2008 I GROUP 1

1	2	3	4	5	6	7	8	9
WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
37	ANESTHESIA	43,820	43,820					
44	LAB	27,137		27,137				
53	EKG	38,697	38,697					
61	ER.	1,245,044	865,430	379,614				
101	TOTAL	1,354,698	947,947	406,751				



COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET  
 I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE	FEET	ENTERED
8	OPERATION OF PLANT	1	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE	FEET	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	PAID HOURS		ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	14	GROSS REV		ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	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 &	496,844	496,844					
005 NEW CAP REL COSTS-MVBLE E	393,189		393,189				
006 EMPLOYEE BENEFITS	1,961,245			1,961,245			
007 ADMINISTRATIVE & GENERAL	2,358,359	33,501	26,512	190,018	2,608,390	2,608,390	
008 MAINTENANCE & REPAIRS	554,454	31,957	25,290	47,674	659,375	109,443	768,818
009 OPERATION OF PLANT	399,905	13,611	10,771		424,287	70,423	24,257
010 LAUNDRY & LINEN SERVICE	149,353	9,405	7,443	2,842	169,043	28,058	16,761
011 HOUSEKEEPING	273,347	1,302	1,030	50,263	325,942	54,100	2,320
012 DIETARY	408,431	3,419	2,706	16,493	431,049	71,546	6,094
014 CAFETERIA	-7,792	3,640	2,880	36,597	35,325	5,863	6,487
017 NURSING ADMINISTRATION	127,084	941	745	28,934	157,704	26,176	1,677
018 MEDICAL RECORDS & LIBRARY	223,139	8,133	6,436	47,950	285,658	47,414	14,494
018 SOCIAL SERVICE	73,169	1,177	931	16,798	92,075	15,283	2,097
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	1,360,787	99,220	78,521	312,724	1,851,252	307,266	176,835
033 INTENSIVE CARE UNIT	198,939	9,802	7,757	45,864	262,362	43,547	17,469
034 NURSERY	89,629	14,964	11,842	21,942	138,377	22,968	26,668
035 SKILLED NURSING FACILITY	590,969	62,891	49,771	134,986	838,617	139,194	112,085
035 NURSING FACILITY	3,390,640				3,390,640		
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	1,329,241	47,737	37,777	248,679	1,663,434	276,097	85,076
041 DELIVERY ROOM & LABOR ROO	26,859	8,125	6,430	6,575	47,989	7,965	14,481
044 RADIOLOGY-DIAGNOSTIC	1,314,368	33,663	26,640	100,329	1,475,000	244,821	59,994
049 LABORATORY	1,519,620	16,677	13,198	162,861	1,712,356	284,217	29,722
050 RESPIRATORY THERAPY	165,635	12,383	9,799	25,336	213,153	35,379	22,068
053 PHYSICAL THERAPY	767,132	7,228	5,720	172,577	952,657	158,122	12,882
055 ELECTROCARDIOLOGY	33,041			8,089	41,130	6,827	
056 MEDICAL SUPPLIES CHARGED	724,057	13,059	10,335	10,467	757,918	125,799	23,274
059 DRUGS CHARGED TO PATIENTS	1,226,177	20,059	15,874	50,232	1,312,342	217,823	35,750
061 PSYCHIATRIC/PSYCHOLOGICAL	276,333	12,758	10,096	38,052	337,239	55,975	22,737
062 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	934,355	17,074	13,512	116,582	1,081,523	179,511	30,429
071 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
071 HOME HEALTH AGENCY	355,615	14,118	11,173	68,381	449,287	74,573	25,161
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	21,714,124	496,844	393,189	1,961,245	21,714,124	2,608,390	768,818
096 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP							
102 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	21,714,124	496,844	393,189	1,961,245	21,714,124	2,608,390	768,818

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
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	518,967						
010 LAUNDRY & LINEN SERVICE	11,683	225,545					
011 HOUSEKEEPING	1,617	6,106	390,085				
012 DIETARY	4,247	3,393	3,277	519,606			
014 CAFETERIA	4,521	3,290	3,488		58,974		
017 NURSING ADMINISTRATION	1,169		902		595	188,223	
018 MEDICAL RECORDS & LIBRARY	10,102		7,793		2,093		367,554
018 SOCIAL SERVICE	1,461		1,127		629		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	123,257	59,301	95,084	168,631	8,364	75,659	28,991
033 INTENSIVE CARE UNIT	12,176	5,174	9,393	19,452	1,029	9,311	4,123
034 NURSERY	18,588	8,532	14,339		621	5,620	1,535
035 SKILLED NURSING FACILITY	78,125	95,681	60,267	331,523	4,981	45,063	6,817
035 NURSING FACILITY					21,949		
037 ANCILLARY SRVC COST CNTRS							
039 OPERATING ROOM	59,299	18,557	45,745		2,284	20,660	24,060
041 DELIVERY ROOM & LABOR ROO	10,093	8,532	7,786		186	1,684	
044 RADIOLOGY-DIAGNOSTIC	41,816		32,258		2,624		94,765
049 LABORATORY	20,716		15,981		4,562		61,787
050 RESPIRATORY THERAPY	15,382		11,866		738		21,616
053 PHYSICAL THERAPY	8,979	7,344	6,927		3,139		18,762
055 ELECTROCARDIOLOGY					236		7,371
056 MEDICAL SUPPLIES CHARGED	16,222		12,514		536		27,746
059 DRUGS CHARGED TO PATIENTS	24,918		19,222		1,067		45,221
059 PSYCHIATRIC/PSYCHOLOGICAL	15,848		12,225				9,346
061 OUTPAT SERVICE COST CNTRS							
062 EMERGENCY	21,210	9,635	16,362		3,341	30,226	15,414
071 OBSERVATION BEDS (NON-DIS							
071 OTHER REIMBURS COST CNTRS							
095 HOME HEALTH AGENCY	17,538		13,529				
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	518,967	225,545	390,085	519,606	58,974	188,223	367,554
096 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP							
102 CROSS FOOT ADJUSTMENT							
103 NEGATIVE COST CENTER							
103 TOTAL	518,967	225,545	390,085	519,606	58,974	188,223	367,554

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	18	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				
017 NURSING ADMINISTRATION				
018 MEDICAL RECORDS & LIBRARY				
SOCIAL SERVICE	112,672			
025 INPAT ROUTINE SRVC CNTRS				
ADULTS & PEDIATRICS	112,672	3,007,312		3,007,312
026 INTENSIVE CARE UNIT		384,036		384,036
033 NURSERY		237,248		237,248
034 SKILLED NURSING FACILITY		1,712,353		1,712,353
035 NURSING FACILITY		3,412,589		3,412,589
ANCILLARY SRVC COST CNTRS				
037 OPERATING ROOM		2,195,212		2,195,212
039 DELIVERY ROOM & LABOR ROO		98,716		98,716
041 RADIOLOGY-DIAGNOSTIC		1,951,278		1,951,278
044 LABORATORY		2,129,341		2,129,341
049 RESPIRATORY THERAPY		320,202		320,202
050 PHYSICAL THERAPY		1,168,812		1,168,812
053 ELECTROCARDIOLOGY		55,564		55,564
055 MEDICAL SUPPLIES CHARGED		964,009		964,009
056 DRUGS CHARGED TO PATIENTS		1,656,343		1,656,343
059 PSYCHIATRIC/PSYCHOLOGICAL		453,370		453,370
OUTPAT SERVICE COST CNTRS				
061 EMERGENCY		1,387,651		1,387,651
062 OBSERVATION BEDS (NON-DIS				
OTHER REIMBURS COST CNTRS				
071 HOME HEALTH AGENCY		580,088		580,088
SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	112,672	21,714,124		21,714,124
NONREIMBURS COST CENTERS				
096 GIFT, FLOWER, COFFEE SHOP				
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 TOTAL	112,672	21,714,124		21,714,124

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL COSTS-BLDG & OSTS 3	NEW CAP REL COSTS-MVBLE E OSTS 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & OSTS							
005 EMPLOYEE BENEFITS							
006 ADMINISTRATIVE & GENERAL		33,501	26,512	60,013		60,013	
007 MAINTENANCE & REPAIRS		31,957	25,290	57,247		2,518	59,765
008 OPERATION OF PLANT		13,611	10,771	24,382		1,620	1,886
009 LAUNDRY & LINEN SERVICE		9,405	7,443	16,848		646	1,303
010 HOUSEKEEPING		1,302	1,030	2,332		1,245	180
011 DIETARY		3,419	2,706	6,125		1,646	474
012 CAFETERIA		3,640	2,880	6,520		135	504
014 NURSING ADMINISTRATION		941	745	1,686		602	130
017 MEDICAL RECORDS & LIBRARY		8,133	6,436	14,569		1,091	1,127
018 SOCIAL SERVICE		1,177	931	2,108		352	163
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		99,220	78,521	177,741		7,068	13,747
026 INTENSIVE CARE UNIT		9,802	7,757	17,559		1,002	1,358
033 NURSERY		14,964	11,842	26,806		528	2,073
034 SKILLED NURSING FACILITY		62,891	49,771	112,662		3,203	8,713
035 NURSING FACILITY							
037 ANCILLARY SRVC COST CNTRS OPERATING ROOM		47,737	37,777	85,514		6,353	6,614
039 DELIVERY ROOM & LABOR ROO		8,125	6,430	14,555		183	1,126
041 RADIOLOGY-DIAGNOSTIC		33,663	26,640	60,303		5,633	4,664
044 LABORATORY		16,677	13,198	29,875		6,539	2,310
049 RESPIRATORY THERAPY		12,383	9,799	22,182		814	1,716
050 PHYSICAL THERAPY		7,228	5,720	12,948		3,638	1,001
053 ELECTROCARDIOLOGY						157	
055 MEDICAL SUPPLIES CHARGED		13,059	10,335	23,394		2,894	1,809
056 DRUGS CHARGED TO PATIENTS		20,059	15,874	35,933		5,012	2,779
059 PSYCHIATRIC/PSYCHOLOGICAL		12,758	10,096	22,854		1,288	1,767
061 OUTPAT SERVICE COST CNTRS EMERGENCY		17,074	13,512	30,586		4,130	2,365
062 OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS)							
071 HOME HEALTH AGENCY		14,118	11,173	25,291		1,716	1,956
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS		496,844	393,189	890,033		60,013	59,765
096 NONREIMBURS COST CENTERS							
101 GIFT, FLOWER, COFFEE SHOP							
102 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		496,844	393,189	890,033		60,013	59,765

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
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	27,888						
010 LAUNDRY & LINEN SERVICE	628	19,425					
011 HOUSEKEEPING	87	526	4,370				
012 DIETARY	228	292		8,802			
013 CAFETERIA	243	283			6,823		
014 NURSING ADMINISTRATION	63				69	2,560	
017 MEDICAL RECORDS & LIBRARY	543				242		17,659
018 SOCIAL SERVICE	79		13		73		
025 INPAT ROUTINE SRVC CNTRS							
026 ADULTS & PEDIATRICS	6,622	5,107	1,066	2,857	968	1,029	1,391
033 INTENSIVE CARE UNIT	654	446	105	330	119	127	198
034 NURSERY	999	735	161		72	76	74
035 SKILLED NURSING FACILITY	4,198	8,240	675	5,615	576	613	327
037 NURSING FACILITY					2,539		
039 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM	3,187	1,598	512		264	281	1,155
044 DELIVERY ROOM & LABOR ROO	542	735	87		22	23	
049 RADIOLOGY-DIAGNOSTIC	2,247		361		304		4,566
050 LABORATORY	1,113		179		528		2,965
053 RESPIRATORY THERAPY	827		133		85		1,037
055 PHYSICAL THERAPY	483	633	78		363		901
056 ELECTROCARDIOLOGY					27		354
059 MEDICAL SUPPLIES CHARGED	872		140		62		1,332
061 DRUGS CHARGED TO PATIENTS	1,339		215		123		2,170
062 PSYCHIATRIC/PSYCHOLOGICAL	852		137				449
071 OUTPAT SERVICE COST CNTRS							
095 EMERGENCY	1,140	830	183		387	411	740
101 OBSERVATION BEDS (NON-DIS							
102 OTHER REIMBURS COST CNTRS							
103 HOME HEALTH AGENCY	942		152				
104 SPEC PURPOSE COST CENTERS							
105 SUBTOTALS	27,888	19,425	4,370	8,802	6,823	2,560	17,659
106 NONREIMBURS COST CENTERS							
107 GIFT, FLOWER, COFFEE SHOP							
108 CROSS FOOT ADJUSTMENTS							
109 NEGATIVE COST CENTER					901		
110 TOTAL	27,888	19,425	4,370	8,802	7,724	2,560	17,659

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	18	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				
017 MEDICAL RECORDS & LIBRARY				
018 SOCIAL SERVICE	2,788			
025 INPAT ROUTINE SRVC CNTRS				
026 ADULTS & PEDIATRICS	2,788	220,384		220,384
033 INTENSIVE CARE UNIT		21,898		21,898
034 NURSERY		31,524		31,524
035 SKILLED NURSING FACILITY		144,822		144,822
037 NURSING FACILITY		2,539		2,539
039 ANCILLARY SRVC COST CNTRS				
041 OPERATING ROOM		105,478		105,478
044 DELIVERY ROOM & LABOR ROO		17,273		17,273
049 RADIOLOGY-DIAGNOSTIC		78,078		78,078
050 LABORATORY		43,509		43,509
053 RESPIRATORY THERAPY		26,794		26,794
055 PHYSICAL THERAPY		20,045		20,045
056 ELECTROCARDIOLOGY		538		538
059 MEDICAL SUPPLIES CHARGED		30,503		30,503
061 DRUGS CHARGED TO PATIENTS		47,571		47,571
062 PSYCHIATRIC/PSYCHOLOGICAL		27,347		27,347
071 OUTPAT SERVICE COST CNTRS				
095 EMERGENCY		40,772		40,772
101 OBSERVATION BEDS (NON-DIS				
102 OTHER REIMBURS COST CNTRS				
103 HOME HEALTH AGENCY		30,057		30,057
104 SPEC PURPOSE COST CENTERS				
105 SUBTOTALS	2,788	889,132		889,132
106 NONREIMBURS COST CENTERS				
107 GIFT, FLOWER, COFFEE SHOP				
108 CROSS FOOT ADJUSTMENTS				
109 NEGATIVE COST CENTER		901		901
110 TOTAL	2,788	890,033		890,033

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

COST CENTER DESCRIPTION	NEW CAP REL	C NEW CAP REL	C EMPLOYEE BENE	RECONCILIATION	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
	OSTS-BLDG & ( SQUARE FEET )	OSTS-MVBLE ( SQUARE FEET )	E FITS ( GROSS SALARIES )		( ACCUM. COST )	( SQUARE FEET )
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	67,569					
005 NEW CAP REL COSTS-MVB		67,569				
006 EMPLOYEE BENEFITS			8,011,359			
007 ADMINISTRATIVE & GENE	4,556	4,556	776,190	-2,608,390	15,715,094	
008 MAINTENANCE & REPAIRS	4,346	4,346	194,742		659,375	58,667
009 OPERATION OF PLANT	1,851	1,851			424,287	1,851
010 LAUNDRY & LINEN SERVI	1,279	1,279	11,609		169,043	1,279
011 HOUSEKEEPING	177	177	205,315		325,942	177
012 DIETARY	465	465	67,370		431,049	465
014 CAFETERIA	495	495	149,492		35,325	495
017 NURSING ADMINISTRATIO	128	128	118,191		157,704	128
018 MEDICAL RECORDS & LIB	1,106	1,106	195,867		285,658	1,106
025 SOCIAL SERVICE	160	160	68,616		92,075	160
026 INPAT ROUTINE SRVC CN						
026 ADULTS & PEDIATRICS	13,494	13,494	1,277,425		1,851,252	13,494
033 INTENSIVE CARE UNIT	1,333	1,333	187,348		262,362	1,333
034 NURSERY	2,035	2,035	89,629		138,377	2,035
035 SKILLED NURSING FACIL	8,553	8,553	551,394		838,617	8,553
037 NURSING FACILITY				-3,390,640		
039 ANCILLARY SRVC COST C						
041 OPERATING ROOM	6,492	6,492	1,015,814		1,663,434	6,492
044 DELIVERY ROOM & LABOR	1,105	1,105	26,859		47,989	1,105
049 RADIOLOGY-DIAGNOSTIC	4,578	4,578	409,827		1,475,000	4,578
050 LABORATORY	2,268	2,268	665,262		1,712,356	2,268
053 RESPIRATORY THERAPY	1,684	1,684	103,494		213,153	1,684
055 PHYSICAL THERAPY	983	983	704,947		952,657	983
056 ELECTROCARDIOLOGY			33,041		41,130	
059 MEDICAL SUPPLIES CHAR	1,776	1,776	42,754		757,918	1,776
061 DRUGS CHARGED TO PATI	2,728	2,728	205,191		1,312,342	2,728
062 PSYCHIATRIC/PSYCHOLOG	1,735	1,735	155,437		337,239	1,735
061 OUTPAT SERVICE COST C						
062 EMERGENCY	2,322	2,322	476,220		1,081,523	2,322
071 OBSERVATION BEDS (NON						
071 OTHER REIMBURS COST C						
071 HOME HEALTH AGENCY	1,920	1,920	279,325		449,287	1,920
095 SPEC PURPOSE COST CEN						
095 SUBTOTALS	67,569	67,569	8,011,359	-5,999,030	15,715,094	58,667
096 NONREIMBURS COST CENT						
101 GIFT, FLOWER, COFFEE						
102 CROSS FOOT ADJUSTMENT						
103 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	496,844	393,189	1,961,245		2,608,390	768,818
104 (WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	7.353135		.244808		.165980	
105 (WRKSHT B, PT I)		5.819074				13.104778
105 COST TO BE ALLOCATED						
106 (WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
107 (WRKSHT B, PT II)						
107 COST TO BE ALLOCATED					60,013	59,765
108 (WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER					.003819	1.018716
108 (WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
		( SQUARE FEET )	( POUNDS OF LAUNDRY )	( SQUARE FEET )	( MEALS SERVED )	( PAID HOURS )	( DIRECT NRSING HRS )	( GROSS REV )
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	56,816						
009	LAUNDRY & LINEN SERVI	1,279	223,136					
010	HOUSEKEEPING	177	6,041	55,360				
011	DIETARY	465	3,357	465	43,274			
012	CAFETERIA	495	3,255	495		451,118		
014	NURSING ADMINISTRATIO	128		128		4,553	159,160	
017	MEDICAL RECORDS & LIB	1,106		1,106		16,013		40,275,497
018	SOCIAL SERVICE	160		160		4,814		
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	13,494	58,668	13,494	14,044	63,977	63,977	3,176,699
026	INTENSIVE CARE UNIT	1,333	5,119	1,333	1,620	7,873	7,873	451,750
033	NURSERY	2,035	8,441	2,035		4,752	4,752	168,150
034	SKILLED NURSING FACIL	8,553	94,657	8,553	27,610	38,105	38,105	746,968
035	NURSING FACILITY					167,882		
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,492	18,359	6,492		17,470	17,470	2,636,403
039	DELIVERY ROOM & LABOR	1,105	8,441	1,105		1,424	1,424	
041	RADIOLOGY-DIAGNOSTIC	4,578		4,578		20,072		10,384,235
044	LABORATORY	2,268		2,268		34,893		6,770,439
049	RESPIRATORY THERAPY	1,684		1,684		5,648		2,368,563
050	PHYSICAL THERAPY	983	7,266	983		24,014		2,055,938
053	ELECTROCARDIOLOGY					1,803		807,732
055	MEDICAL SUPPLIES CHAR	1,776		1,776		4,102		3,040,347
056	DRUGS CHARGED TO PATI	2,728		2,728		8,164		4,955,131
059	PSYCHIATRIC/PSYCHOLOG	1,735		1,735				1,024,079
	OUTPAT SERVICE COST C							
061	EMERGENCY	2,322	9,532	2,322		25,559	25,559	1,689,063
062	OBSERVATION BEDS (NON							
	OTHER REIMBURS COST C							
071	HOME HEALTH AGENCY	1,920		1,920				
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	56,816	223,136	55,360	43,274	451,118	159,160	40,275,497
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	518,967	225,545	390,085	519,606	58,974	188,223	367,554
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		1.010796		12.007349		1.182602	
	(WRKSHT B, PT I)	9.134170		7.046333		.130729		.009126
105	COST TO BE ALLOCATED							
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	27,888	19,425	4,370	8,802	6,823	2,560	17,659
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		.087055		.203402		.016084	
	(WRKSHT B, PT III)	.490848		.078938		.015125		.000438

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

COST CENTER DESCRIPTION	SOCIAL SERVICE	( TIME SPENT )
		18
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		
017 NURSING ADMINISTRATIO		
018 MEDICAL RECORDS & LIB	100	
025 SOCIAL SERVICE		
026 INPAT ROUTINE SRVC CN	100	
033 ADULTS & PEDIATRICS		
034 INTENSIVE CARE UNIT		
035 NURSERY		
037 SKILLED NURSING FACIL		
039 NURSING FACILITY		
041 ANCILLARY SRVC COST C		
044 OPERATING ROOM		
049 DELIVERY ROOM & LABOR		
050 RADIOLOGY-DIAGNOSTIC		
053 LABORATORY		
055 RESPIRATORY THERAPY		
056 PHYSICAL THERAPY		
059 ELECTROCARDIOLOGY		
061 MEDICAL SUPPLIES CHAR		
062 DRUGS CHARGED TO PATI		
071 PSYCHIATRIC/PSYCHOLOG		
095 OUTPAT SERVICE COST C		
EMERGENCY		
OBSERVATION BEDS (NON		
OTHER REIMBURS COST C		
HOME HEALTH AGENCY		
SPEC PURPOSE COST CEN		
SUBTOTALS	100	
NONREIMBURS COST CENT		
GIFT, FLOWER, COFFEE		
CROSS FOOT ADJUSTMENT		
NEGATIVE COST CENTER		
COST TO BE ALLOCATED	112,672	
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		
(WRKSHT B, PT I)	1,126.720000	
COST-TO-BE-ALLOCATED		
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		
(WRKSHT B, PT II)		
COST TO BE ALLOCATED	2,788	
(PER WRKSHT B, PART		
UNIT COST MULTIPLIER		
(WRKSHT B, PT III)	27.880000	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 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	3,007,312		3,007,312		3,007,312
26	INTENSIVE CARE UNIT	384,036		384,036		384,036
33	NURSERY	237,248		237,248		237,248
34	SKILLED NURSING FACILITY	1,712,353		1,712,353		1,712,353
35	NURSING FACILITY	3,412,589		3,412,589		3,412,589
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,195,212		2,195,212		2,195,212
39	DELIVERY ROOM & LABOR ROO	98,716		98,716		98,716
41	RADIOLOGY-DIAGNOSTIC	1,951,278		1,951,278		1,951,278
44	LABORATORY	2,129,341		2,129,341		2,129,341
49	RESPIRATORY THERAPY	320,202		320,202		320,202
50	PHYSICAL THERAPY	1,168,812		1,168,812		1,168,812
53	ELECTROCARDIOLOGY	55,564		55,564		55,564
55	MEDICAL SUPPLIES CHARGED	964,009		964,009		964,009
56	DRUGS CHARGED TO PATIENTS	1,656,343		1,656,343		1,656,343
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	453,370		453,370		453,370
61	EMERGENCY	1,387,651		1,387,651		1,387,651
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557		414,557		414,557
101	SUBTOTAL	21,548,593		21,548,593		21,548,593
102	LESS OBSERVATION BEDS	414,557		414,557		414,557
103	TOTAL	21,134,036		21,134,036		21,134,036

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 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	2,796,529		2,796,529			
26	INTENSIVE CARE UNIT	451,750		451,750			
33	NURSERY	168,150		168,150			
34	SKILLED NURSING FACILITY	746,968		746,968			
35	NURSING FACILITY	5,339,075		5,339,075			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	646,473	1,989,930	2,636,403	.832654	.832654	.832654
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC	1,473,178	8,911,057	10,384,235	.187908	.187908	.187908
44	LABORATORY	1,832,453	4,937,986	6,770,439	.314506	.314506	.314506
49	RESPIRATORY THERAPY	580,765	849,135	1,429,900	.223933	.223933	.223933
50	PHYSICAL THERAPY	676,944	1,378,994	2,055,938	.568505	.568505	.568505
53	ELECTROCARDIOLOGY	270,477	537,255	807,732	.068790	.068790	.068790
55	MEDICAL SUPPLIES CHARGED	2,057,769	1,921,240	3,979,009	.242274	.242274	.242274
56	DRUGS CHARGED TO PATIENTS	2,665,127	2,290,004	4,955,131	.334268	.334268	.334268
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS		1,024,079	1,024,079	.442710	.442710	.442710
61	EMERGENCY	191,673	1,497,390	1,689,063	.821551	.821551	.821551
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	26,760	353,410	380,170	1.090452	1.090452	1.090452
101	SUBTOTAL	19,924,091	25,690,480	45,614,571			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,924,091	25,690,480	45,614,571			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 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	3,007,312		3,007,312		3,007,312
26	INTENSIVE CARE UNIT	384,036		384,036		384,036
33	NURSERY	237,248		237,248		237,248
34	SKILLED NURSING FACILITY	1,712,353		1,712,353		1,712,353
35	NURSING FACILITY	3,412,589		3,412,589		3,412,589
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	2,195,212		2,195,212		2,195,212
39	DELIVERY ROOM & LABOR ROO	98,716		98,716		98,716
41	RADIOLOGY-DIAGNOSTIC	1,951,278		1,951,278		1,951,278
44	LABORATORY	2,129,341		2,129,341		2,129,341
49	RESPIRATORY THERAPY	320,202		320,202		320,202
50	PHYSICAL THERAPY	1,168,812		1,168,812		1,168,812
53	ELECTROCARDIOLOGY	55,564		55,564		55,564
55	MEDICAL SUPPLIES CHARGED	964,009		964,009		964,009
56	DRUGS CHARGED TO PATIENTS	1,656,343		1,656,343		1,656,343
59	PSYCHIATRIC/PSYCHOLOGICAL	453,370		453,370		453,370
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,387,651		1,387,651		1,387,651
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557		414,557		414,557
101	SUBTOTAL	21,548,593		21,548,593		21,548,593
102	LESS OBSERVATION BEDS	414,557		414,557		414,557
103	TOTAL	21,134,036		21,134,036		21,134,036

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 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	2,796,529		2,796,529			
26	INTENSIVE CARE UNIT	451,750		451,750			
33	NURSERY	168,150		168,150			
34	SKILLED NURSING FACILITY	746,968		746,968			
35	NURSING FACILITY	5,339,075		5,339,075			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	646,473	1,989,930	2,636,403	.832654	.832654	.832654
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC	1,473,178	8,911,057	10,384,235	.187908	.187908	.187908
44	LABORATORY	1,832,453	4,937,986	6,770,439	.314506	.314506	.314506
49	RESPIRATORY THERAPY	580,765	849,135	1,429,900	.223933	.223933	.223933
50	PHYSICAL THERAPY	676,944	1,378,994	2,055,938	.568505	.568505	.568505
53	ELECTROCARDIOLOGY	270,477	537,255	807,732	.068790	.068790	.068790
55	MEDICAL SUPPLIES CHARGED	2,057,769	1,921,240	3,979,009	.242274	.242274	.242274
56	DRUGS CHARGED TO PATIENTS	2,665,127	2,290,004	4,955,131	.334268	.334268	.334268
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS		1,024,079	1,024,079	.442710	.442710	.442710
61	EMERGENCY	191,673	1,497,390	1,689,063	.821551	.821551	.821551
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	26,760	353,410	380,170	1.090452	1.090452	1.090452
101	SUBTOTAL	19,924,091	25,690,480	45,614,571			
102	LESS OBSERVATION BEDS						
103	TOTAL	19,924,091	25,690,480	45,614,571			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,195,212	105,478	2,089,734			2,195,212
39	DELIVERY ROOM & LABOR ROO	98,716	17,273	81,443			98,716
41	RADIOLOGY-DIAGNOSTIC	1,951,278	78,078	1,873,200			1,951,278
44	LABORATORY	2,129,341	43,509	2,085,832			2,129,341
49	RESPIRATORY THERAPY	320,202	26,794	293,408			320,202
50	PHYSICAL THERAPY	1,168,812	20,045	1,148,767			1,168,812
53	ELECTROCARDIOLOGY	55,564	538	55,026			55,564
55	MEDICAL SUPPLIES CHARGED	964,009	30,503	933,506			964,009
56	DRUGS CHARGED TO PATIENTS	1,656,343	47,571	1,608,772			1,656,343
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	453,370	27,347	426,023			453,370
61	EMERGENCY	1,387,651	40,772	1,346,879			1,387,651
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557		414,557			414,557
101	SUBTOTAL	12,795,055	437,908	12,357,147			12,795,055
102	LESS OBSERVATION BEDS	414,557		414,557			414,557
103	TOTAL	12,380,498	437,908	11,942,590			12,380,498

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	2,636,403	.832654	.832654
39	DELIVERY ROOM & LABOR ROO			
41	RADIOLOGY-DIAGNOSTIC	10,384,235	.187908	.187908
44	LABORATORY	6,770,439	.314506	.314506
49	RESPIRATORY THERAPY	1,429,900	.223933	.223933
50	PHYSICAL THERAPY	2,055,938	.568505	.568505
53	ELECTROCARDIOLOGY	807,732	.068790	.068790
55	MEDICAL SUPPLIES CHARGED	3,979,009	.242274	.242274
56	DRUGS CHARGED TO PATIENTS	4,955,131	.334268	.334268
59	PSYCHIATRIC/PSYCHOLOGICAL	1,024,079	.442710	.442710
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,689,063	.821551	.821551
62	OBSERVATION BEDS (NON-DIS	380,170	1.090452	1.090452
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	36,112,099		
102	LESS OBSERVATION BEDS	380,170		
103	TOTAL	35,731,929		

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 REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	2,195,212	105,478	2,089,734			2,195,212
39	DELIVERY ROOM & LABOR ROO	98,716	17,273	81,443			98,716
41	RADIOLOGY-DIAGNOSTIC	1,951,278	78,078	1,873,200			1,951,278
44	LABORATORY	2,129,341	43,509	2,085,832			2,129,341
49	RESPIRATORY THERAPY	320,202	26,794	293,408			320,202
50	PHYSICAL THERAPY	1,168,812	20,045	1,148,767			1,168,812
53	ELECTROCARDIOLOGY	55,564	538	55,026			55,564
55	MEDICAL SUPPLIES CHARGED	964,009	30,503	933,506			964,009
56	DRUGS CHARGED TO PATIENTS	1,656,343	47,571	1,608,772			1,656,343
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	453,370	27,347	426,023			453,370
61	EMERGENCY	1,387,651	40,772	1,346,879			1,387,651
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557		414,557			414,557
101	SUBTOTAL	12,795,055	437,908	12,357,147			12,795,055
102	LESS OBSERVATION BEDS	414,557		414,557			414,557
103	TOTAL	12,380,498	437,908	11,942,590			12,380,498

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	2,636,403	.832654	.832654
39	DELIVERY ROOM & LABOR ROO			
41	RADIOLOGY-DIAGNOSTIC	10,384,235	.187908	.187908
44	LABORATORY	6,770,439	.314506	.314506
49	RESPIRATORY THERAPY	1,429,900	.223933	.223933
50	PHYSICAL THERAPY	2,055,938	.568505	.568505
53	ELECTROCARDIOLOGY	807,732	.068790	.068790
55	MEDICAL SUPPLIES CHARGED	3,979,009	.242274	.242274
56	DRUGS CHARGED TO PATIENTS	4,955,131	.334268	.334268
59	PSYCHIATRIC/PSYCHOLOGICAL	1,024,079	.442710	.442710
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,689,063	.821551	.821551
62	OBSERVATION BEDS (NON-DIS	380,170	1.090452	1.090452
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	36,112,099		
102	LESS OBSERVATION BEDS	380,170		
103	TOTAL	35,731,929		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
37	ANCILLARY SRVC COST CNTRS					
	OPERATING ROOM	2,195,212	2,636,403			
39	DELIVERY ROOM & LABOR ROO	98,716				
41	RADIOLOGY-DIAGNOSTIC	1,951,278	10,384,235			
44	LABORATORY	2,129,341	6,770,439			
49	RESPIRATORY THERAPY	320,202	1,429,900			
50	PHYSICAL THERAPY	1,168,812	2,055,938			
53	ELECTROCARDIOLOGY	55,564	807,732			
55	MEDICAL SUPPLIES CHARGED	964,009	3,979,009			
56	DRUGS CHARGED TO PATIENTS	1,656,343	4,955,131			
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	453,370	1,024,079			
61	EMERGENCY	1,387,651	1,689,063			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557	380,170			
101	TOTAL	12,795,055	36,112,099			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1311 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	2,195,212	43,820	2,239,032	2,636,403			
39	DELIVERY ROOM & LABOR ROO	98,716		98,716				
41	RADIOLOGY-DIAGNOSTIC	1,951,278		1,951,278	10,384,235			
44	LABORATORY	2,129,341		2,129,341	6,770,439			
49	RESPIRATORY THERAPY	320,202		320,202	1,429,900			
50	PHYSICAL THERAPY	1,168,812		1,168,812	2,055,938			
53	ELECTROCARDIOLOGY	55,564	38,697	94,261	807,732			
55	MEDICAL SUPPLIES CHARGED	964,009		964,009	3,979,009			
56	DRUGS CHARGED TO PATIENTS	1,656,343		1,656,343	4,955,131			
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS	453,370		453,370	1,024,079			
61	EMERGENCY	1,387,651	865,430	2,253,081	1,689,063			
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS	414,557		414,557	380,170			
101	TOTAL	12,795,055	947,947	13,743,002	36,112,099			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.832654		.832654		
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC	.187908		.187908		
44 LABORATORY	.314506		.314506		
49 RESPIRATORY THERAPY	.223933		.223933		
50 PHYSICAL THERAPY	.568505		.568505		
53 ELECTROCARDIOLOGY	.068790		.068790		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.242274		.242274		
56 DRUGS CHARGED TO PATIENTS	.334268		.334268		
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.442710		.442710		
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY	.821551		.821551		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.090452		1.090452		
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	4	5	6	7	8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		591,242			
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC		3,387,368			
44 LABORATORY		1,676,380			
49 RESPIRATORY THERAPY		314,691			
50 PHYSICAL THERAPY		583,591			
53 ELECTROCARDIOLOGY		211,517			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		909,230			
56 DRUGS CHARGED TO PATIENTS		959,382			
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,024,079			
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY		363,270			
62 OBSERVATION BEDS (NON-DISTINCT PART)		303,914			
101 SUBTOTAL		10,324,664			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		10,324,664			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1311 I I

TITLE XVIII, PART B

HOSPITAL

	All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description	9	10	11
(A) ANCILLARY SRVC COST CNTRS			
37 OPERATING ROOM	492,300		
39 DELIVERY ROOM & LABOR ROOM			
41 RADIOLOGY-DIAGNOSTIC	636,514		
44 LABORATORY	527,232		
49 RESPIRATORY THERAPY	70,470		
50 PHYSICAL THERAPY	331,774		
53 ELECTROCARDIOLOGY	14,550		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	220,283		
56 DRUGS CHARGED TO PATIENTS	320,691		
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	453,370		
OUTPAT SERVICE COST CNTRS			
61 EMERGENCY	298,445		
62 OBSERVATION BEDS (NON-DISTINCT PART)	331,404		
101 SUBTOTAL	3,697,033		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	3,697,033		

(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

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1
2	PROGRAM VACCINE CHARGES	.334268
3	PROGRAM COSTS	174
		58

TITLE XVIII, PART A SKILLED NURSING FACILITY 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	CAPITAL COSTS 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996) CONTD  
 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART II  
 I 14-5552 I PPS

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A	COST CENTER DESCRIPTION	NEW CAPITAL
LINE NO.		CST/CHRG RATIO COSTS
		7 8
37	ANCILLARY SRVC COST CNTRS	
	OPERATING ROOM	
39	DELIVERY ROOM & LABOR ROO	
41	RADIOLOGY-DIAGNOSTIC	
44	LABORATORY	
49	RESPIRATORY THERAPY	
50	PHYSICAL THERAPY	
53	ELECTROCARDIOLOGY	
55	MEDICAL SUPPLIES CHARGED	
56	DRUGS CHARGED TO PATIENTS	
59	PSYCHIATRIC/PSYCHOLOGICAL	
	OUTPAT SERVICE COST CNTRS	
61	EMERGENCY	
62	OBSERVATION BEDS (NON-DIS	
	OTHER REIMBURS COST CNTRS	
101	TOTAL	

TITLE XVIII, PART A SKILLED NURSING FACILITY 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
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM							
39	DELIVERY ROOM & LABOR ROO							
41	RADIOLOGY-DIAGNOSTIC							
44	LABORATORY							
49	RESPIRATORY THERAPY							
50	PHYSICAL THERAPY							
53	ELECTROCARDIOLOGY							
55	MEDICAL SUPPLIES CHARGED							
56	DRUGS CHARGED TO PATIENTS							
59	PSYCHIATRIC/PSYCHOLOGICAL							
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY							
62	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
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 COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM			2,636,403				
39	DELIVERY ROOM & LABOR ROO							
41	RADIOLOGY-DIAGNOSTIC			10,384,235			34,991	
44	LABORATORY			6,770,439			87,899	
49	RESPIRATORY THERAPY			1,429,900			116,700	
50	PHYSICAL THERAPY			2,055,938			406,655	
53	ELECTROCARDIOLOGY			807,732			2,686	
55	MEDICAL SUPPLIES CHARGED			3,979,009			377,165	
56	DRUGS CHARGED TO PATIENTS			4,955,131			192,727	
59	PSYCHIATRIC/PSYCHOLOGICAL OUTPAT SERVICE COST CNTRS			1,024,079				
61	EMERGENCY			1,689,063				
62	OBSERVATION BEDS (NON-DIS OTHER REIMBURS COST CNTRS			380,170				
101	TOTAL			36,112,099			1,218,823	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-5552 I I

TITLE XVIII, PART B

SKILLED NURSING FACILITY

Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	1	1.02	2	3	4
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.832654	.832654			
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC	.187908	.187908			
44 LABORATORY	.314506	.314506			
49 RESPIRATORY THERAPY	.223933	.223933			
50 PHYSICAL THERAPY	.568505	.568505			
53 ELECTROCARDIOLOGY	.068790	.068790			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.242274	.242274			
56 DRUGS CHARGED TO PATIENTS	.334268	.334268			
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.442710	.442710			
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY	.821551	.821551			
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.090452	1.090452			
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-5552 I I

TITLE XVIII, PART B

SKILLED NURSING FACILITY

Cost Center Description	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other
	5	6	7	8	9
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY	201				63
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
53 ELECTROCARDIOLOGY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS	419				140
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
101 SUBTOTAL	620				203
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES	620				203

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/21/2008
I	14-1311	I	FROM 7/ 1/2007	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2008	I	PART V
I	14-5552	I		I	

TITLE XVIII, PART B

SKILLED NURSING FACILITY

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

Cost Center Description

10

11

- (A) ANCILLARY SRVC COST CNTRS
- 37 OPERATING ROOM
- 39 DELIVERY ROOM & LABOR ROOM
- 41 RADIOLOGY-DIAGNOSTIC
- 44 LABORATORY
- 49 RESPIRATORY THERAPY
- 50 PHYSICAL THERAPY
- 53 ELECTROCARDIOLOGY
- 55 MEDICAL SUPPLIES CHARGED TO PATIENTS
- 56 DRUGS CHARGED TO PATIENTS
- 59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES
- 61 OUTPAT SERVICE COST CNTRS
- 62 EMERGENCY
- 62 OBSERVATION BEDS (NON-DISTINCT PART)
- 101 SUBTOTAL
- 102 CRNA CHARGES
- 103 LESS PBP CLINIC LAB SVCS-
- 104 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 XIX - O/P		HOSPITAL				
		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
Cost Center Description		1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.832654				403,110
39	DELIVERY ROOM & LABOR ROOM					1,959,743
41	RADIOLOGY-DIAGNOSTIC	.187908				914,734
44	LABORATORY	.314506				123,506
49	RESPIRATORY THERAPY	.223933				112,624
50	PHYSICAL THERAPY	.568505				86,974
53	ELECTROCARDIOLOGY	.068790				365,605
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.242274				451,719
56	DRUGS CHARGED TO PATIENTS	.334268				
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.442710				
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.821551				478,149
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.090452				
101	SUBTOTAL					4,896,164
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					4,896,164

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

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A) ANCILLARY SRVC COST CNTRS	5.01	5.02	5.03	6	7
37 OPERATING ROOM					
39 DELIVERY ROOM & LABOR ROOM					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
53 ELECTROCARDIOLOGY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
61 OUTPAT SERVICE COST CNTRS					
62 EMERGENCY					
101 OBSERVATION BEDS (NON-DISTINCT PART)					
102 SUBTOTAL					
103 CRNA CHARGES					
104 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

TITLE XIX - O/P	HOSPITAL	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
Cost Center Description		8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS						
37 OPERATING ROOM			335,651			
39 DELIVERY ROOM & LABOR ROOM						
41 RADIOLOGY-DIAGNOSTIC			368,251			
44 LABORATORY			287,689			
49 RESPIRATORY THERAPY			27,657			
50 PHYSICAL THERAPY			64,027			
53 ELECTROCARDIOLOGY			5,983			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS			88,577			
56 DRUGS CHARGED TO PATIENTS			150,995			
59 PSYCHIATRIC/PSYCHOLOGICAL SERVICES						
61 OUTPAT SERVICE COST CNTRS						
62 EMERGENCY			392,824			
62 OBSERVATION BEDS (NON-DISTINCT PART)						
101 SUBTOTAL			1,721,654			
102 CRNA CHARGES						
103 LESS PBP CLINIC LAB SVCS-						
PROGRAM ONLY CHARGES						
104 NET CHARGES			1,721,654			

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,852
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,852
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,852
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,098
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,007,312
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	3,007,312

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,344,849
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,344,849
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.899088
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	868.34
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	3,007,312

TITLE XVIII PART A HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 780.71  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,637,930  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 1,637,930

	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	384,036	383	1,002.70	282	282,761
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1 1,752,884
49 TOTAL PROGRAM INPATIENT COSTS					3,673,575

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES  
 52 TOTAL PROGRAM EXCLUDABLE COST  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES  
 55 TARGET AMOUNT PER DISCHARGE  
 56 TARGET AMOUNT  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT  
 58 BONUS PAYMENT  
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED  
 AND COMPOUNDED BY THE MARKET BASKET  
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET  
 BASKET  
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE  
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN  
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)  
 OTHERWISE ENTER ZERO.  
 58.04 RELIEF PAYMENT  
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT  
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)  
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1  
 59.03 PROGRAM DISCHARGES AFTER JULY 1  
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)  
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	531
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	780.71
85	OBSERVATION BED COST	414,557

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,579
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,579
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,579
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,627
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 XVII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,712,353
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	1,712,353

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.292405
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	113.54
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	1,712,353

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	1,712,353
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	260.28
68	PROGRAM ROUTINE SERVICE COST	683,756
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	683,756
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	144,822
72	PER DIEM CAPITAL-RELATED COSTS	22.01
73	PROGRAM CAPITAL-RELATED COSTS	57,820
74	INPATIENT ROUTINE SERVICE COST	625,936
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	625,936
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	683,756
80	PROGRAM INPATIENT ANCILLARY SERVICES	447,522
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	1,131,278

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,852
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,852
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,852
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	507
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)	297
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,007,312
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	3,007,312

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,344,849
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,344,849
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.899088
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	868.34
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	3,007,312

TITLE XIX - I/P

HOSPITAL

OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE  
 PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 780.71  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 395,820  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 395,820

	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST
	1	2	3	4	5
42 NURSERY (TITLE V & XIX ONLY) INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS	237,248	297	798.81		
43 INTENSIVE CARE UNIT	384,036	383	1,002.70		
44 CORONARY CARE UNIT					
45 BURN INTENSIVE CARE UNIT					
46 SURGICAL INTENSIVE CARE UNIT					
47 OTHER SPECIAL CARE					
48 PROGRAM INPATIENT ANCILLARY SERVICE COST					1
49 TOTAL PROGRAM INPATIENT COSTS					482,343 878,163

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES  
 52 TOTAL PROGRAM EXCLUDABLE COST  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN  
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES  
 55 TARGET AMOUNT PER DISCHARGE  
 56 TARGET AMOUNT  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT  
 58 BONUS PAYMENT  
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED  
 AND COMPOUNDED BY THE MARKET BASKET  
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET  
 BASKET  
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE  
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN  
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)  
 OTHERWISE ENTER ZERO.  
 58.04 RELIEF PAYMENT  
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT  
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)  
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1  
 59.03 PROGRAM DISCHARGES AFTER JULY 1  
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)  
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1  
 (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)  
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

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

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	531
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	780.71
85	OBSERVATION BED COST	414,557

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				

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART I  
 I 14-5552 I I

TITLE XIX - I/P SNF OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,579
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,579
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,579
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

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

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	746,968
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	113.54
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

TITLE XIX - I/P SNF OTHER

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST		1
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		
68	PROGRAM ROUTINE SERVICE COST		
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	144,822	
72	PER DIEM CAPITAL-RELATED COSTS	22.01	
73	PROGRAM CAPITAL-RELATED COSTS		
74	INPATIENT ROUTINE SERVICE COST		
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION		
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS		
80	PROGRAM INPATIENT ANCILLARY SERVICES		
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS		

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P NF OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	30,698
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	30,698
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	30,698
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	23,231
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,412,589
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	3,412,589

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,339,075
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,339,075
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.639172
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	173.92
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	3,412,589

TITLE XIX - I/P NF OTHER

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1	3,412,589
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	111.17	
68	PROGRAM ROUTINE SERVICE COST	2,582,590	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	2,582,590	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	2,539	
72	PER DIEM CAPITAL-RELATED COSTS	.08	
73	PROGRAM CAPITAL-RELATED COSTS	1,858	
74	INPATIENT ROUTINE SERVICE COST	2,580,732	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	2,580,732	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		
78	INPATIENT ROUTINE SERVICE COST LIMITATION		
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	1,858	
80	PROGRAM INPATIENT ANCILLARY SERVICES		
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION		
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	1,858	

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 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-1311 I I

TITLE XVIII, PART A

HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,458,826	
26	INTENSIVE CARE UNIT ANCILLARY SRVC COST CNTRS		318,660	
37	OPERATING ROOM	.832654	197,037	164,064
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.187908	1,003,438	188,554
44	LABORATORY	.314506	1,214,144	381,856
49	RESPIRATORY THERAPY	.223933	352,985	79,045
50	PHYSICAL THERAPY	.568505	110,078	62,580
53	ELECTROCARDIOLOGY	.068790	159,814	10,994
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.242274	1,007,551	244,103
56	DRUGS CHARGED TO PATIENTS	.334268	1,552,044	518,799
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES OUTPAT SERVICE COST CNTRS	.442710		
61	EMERGENCY	.821551	125,238	102,889
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.090452		
101	TOTAL		5,722,329	1,752,884
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		5,722,329	

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			
26	INTENSIVE CARE UNIT			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.832654		
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.187908	34,991	6,575
44	LABORATORY	.314506	87,899	27,645
49	RESPIRATORY THERAPY	.223933	116,700	26,133
50	PHYSICAL THERAPY	.568505	406,655	231,185
53	ELECTROCARDIOLOGY	.068790	2,686	185
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.242274	377,165	91,377
56	DRUGS CHARGED TO PATIENTS	.334268	192,727	64,422
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES OUTPAT SERVICE COST CNTRS	.442710		
61	EMERGENCY	.821551		
62	OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURS COST CNTRS	1.090452		
101	TOTAL		1,218,823	447,522
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,218,823	



PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	3,697,091
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	3,697,091

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES		
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	3,734,062
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	CAH DEDUCTIBLES	52,937
18.01	CAH ACTUAL BILLED COINSURANCE	1,731,514
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,949,611
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,949,611
24	PRIMARY PAYER PAYMENTS	491
25	SUBTOTAL	1,949,120

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	261,441
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	261,441
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	2,210,561
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,210,561
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,962,918
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	247,643
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

PART B - MEDICAL AND OTHER HEALTH SERVICES

SNF

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	203
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	203

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	620
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	620
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)	620
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	417
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	203
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	40
19	SUBTOTAL (SEE INSTRUCTIONS)	163
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	163
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	163

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	163
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	163
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	163
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	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.		2,562,774		1,962,918
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				
SUBTOTAL				
4 TOTAL INTERIM PAYMENTS		2,562,774		1,962,918
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				
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	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		660,662		84
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.		4		79
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		660,666		163
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

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1311	I FROM 7/ 1/2007	I WORKSHEET E-3
I COMPONENT NO:	I TO 6/30/2008	I PART II
I 14-1311	I	I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	3,673,575
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,673,575
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,710,311

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
8	ROUTINE SERVICE CHARGES	
9	ANCILLARY SERVICE CHARGES	
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
11	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
13	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
14	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)	
15	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	3,710,311
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	509,310
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,201,001
23	COINSURANCE	5,592
24	SUBTOTAL	3,195,409
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	112,434
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	112,434
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,307,843
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,307,843
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,562,774
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	745,069
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET E-3  
 I COMPONENT NO: I TO 6/30/2008 I PART III  
 I 14-5552 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	
COMPUTATION OF NET COST OF COVERED SERVICE					
1	INPATIENT HOSPITAL/SNF/NF SERVICES				
2	MEDICAL AND OTHER SERVICES				
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)				
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)				
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)				
6	SUBTOTAL				
7	INPATIENT PRIMARY PAYER PAYMENTS				
8	OUTPATIENT PRIMARY PAYER PAYMENTS				
9	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 PAYMENT FOR SERVICES ON A CHARGE BASIS				
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				
19	RATIO OF LINE 17 TO LINE 18				
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				
23	COST OF COVERED SERVICES				
PROSPECTIVE PAYMENT AMOUNT					
24	OTHER THAN OUTLIER PAYMENTS				824,528
25	OUTLIER PAYMENTS				
26	PROGRAM CAPITAL PAYMENTS				
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)				
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS				
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS				
30	SUBTOTAL				824,528
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)				
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30				824,528
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)				1,046
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
34	EXCESS OF REASONABLE COST				
35	SUBTOTAL				823,482
36	COINSURANCE				162,816
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19				
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)				
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)				
39	UTILIZATION REVIEW				
40	SUBTOTAL (SEE INSTRUCTIONS)				660,666
41	INPATIENT ROUTINE SERVICE COST				
42	MEDICARE INPATIENT ROUTINE CHARGES				
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES				
45	RATIO OF LINE 43 TO 44				
46	TOTAL CUSTOMARY CHARGES				
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				
50	OTHER ADJUSTMENTS (SPECIFY)				
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				
52	SUBTOTAL				660,666
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)				
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER				660,666
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)				
57	INTERIM PAYMENTS				660,666
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				
58	BALANCE DUE PROVIDER/PROGRAM				

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1311	I FROM 7/ 1/2007	I WORKSHEET E-3
I COMPONENT NO:	I TO 6/30/2008	I PART III
I 14-5552	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

59 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

1

2



	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,521,938			
29 SALARIES, WAGES & FEES PAYABLE	244,880			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	346,910			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS				
35 OTHER CURRENT LIABILITIES	507,676			
36 TOTAL CURRENT LIABILITIES	2,621,404			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	1,747,383			
38 NOTES PAYABLE				
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES				
42 TOTAL LONG-TERM LIABILITIES	1,747,383			
43 TOTAL LIABILITIES	4,368,787			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	13,726,179			
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	13,726,179			
52 TOTAL LIABILITIES AND FUND BALANCES	18,094,966			



PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	3,344,849		3,344,849
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	746,968		746,968
7 00 NURSING FACILITY	5,339,075		5,339,075
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	9,430,892		9,430,892
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10 00 INTENSIVE CARE UNIT	451,750		451,750
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	451,750		451,750
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	9,882,642		9,882,642
17 00 ANCILLARY SERVICES	10,394,859	25,337,071	35,731,930
18 00 OUTPATIENT SERVICES			
19 00 HOME HEALTH AGENCY		722,902	722,902
24 00	648,646	3,255,730	3,904,376
25 00 TOTAL PATIENT REVENUES	20,926,147	29,315,703	50,241,850

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		23,282,535	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)	3,916,738		
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS		3,916,738	
40 00 TOTAL OPERATING EXPENSES		19,365,797	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET G-3  
 I I TO 6/30/2008 I

DESCRIPTION		
1	TOTAL PATIENT REVENUES	50,241,850
2	LESS: ALLOWANCES AND DISCOUNTS ON	25,784,005
3	NET PATIENT REVENUES	24,457,845
4	LESS: TOTAL OPERATING EXPENSES	19,365,797
5	NET INCOME FROM SERVICE TO PATIENT	5,092,048
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	188,752
24.10		93,429
25	TOTAL OTHER INCOME	282,181
26	TOTAL	5,374,229
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	5,339,075
28		
29		
30	TOTAL OTHER EXPENSES	5,339,075
31	NET INCOME (OR LOSS) FOR THE PERIO	35,154

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		79,325			56,285	135,610
HHA REIMBURSABLE SERVICES						
6		200,000				200,000
7						
8						
9						
10						
11						
12					21,626	21,626
13						
13.20						
14						
HHA NONREIMBURSABLE SERVICES						
15						
16						
17						
18						
19						
20						
21						
22						
23						
23.50						
24		279,325			77,911	357,236

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10
GENERAL SERVICE COST CENTERS				
1				
2				
3				
4				
5				
5	-1,621	133,989		133,989
HHA REIMBURSABLE SERVICES				
6		200,000		200,000
7				
8				
9				
10				
11				
12		21,626		21,626
13				
13.20				
14				
HHA NONREIMBURSABLE SERVICES				
15				
16				
17				
18				
19				
20				
21				
22				
23				
23.50				
24	-1,621	355,615		355,615

HHA 1

	NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
	0	1	2	3	4	4A	5
GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5	133,989					133,989	133,989
HHA REIMBURSABLE SERVICES							
6	200,000					200,000	120,915
7							
8							
9							
10							
11							
12	21,626					21,626	13,074
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	355,615					355,615	

TOTAL

6

GENERAL SERVICE COST CENTERS							
1							
2							
3							
4							
5							
HHA REIMBURSABLE SERVICES							
6	320,915						
7							
8							
9							
10							
11							
12	34,700						
13							
13.20							
14							
HHA NONREIMBURSABLE SERVICES							
15							
16							
17							
18							
19							
20							
21							
22							
23							
23.50							
24	355,615						

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					
	HHA REIMBURSABLE SERVICES				-133,989	221,626
6	SKILLED NURSING CARE					200,000
7	PHYSICAL THERAPY					
8	OCCUPATIONAL THERAPY					
9	SPEECH PATHOLOGY					
10	MEDICAL SOCIAL SERVICES					
11	HOME HEALTH AIDE					
12	SUPPLIES					21,626
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					
23.50	TELEMEDICINE					
24	TOTAL (SUM OF LINES 1-23)				-133,989	221,626
25	COST TO BE ALLOCATED					133,989
26	UNIT COST MULTIPLIER					.604573

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		14,118	11,173	68,381	93,672	15,548
2 SKILLED NURSING CARE	320,915				320,915	53,265
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES	34,700				34,700	5,760
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)	355,615	14,118	11,173	68,381	449,287	74,573
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	25,161	17,538		13,529		
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)	25,161	17,538		13,529		
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	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27
1 ADMIN & GENERAL				165,448		165,448
2 SKILLED NURSING CARE				374,180		374,180
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES				40,460		40,460
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)				580,088		580,088
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	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1 ADMIN & GENERAL		
2 SKILLED NURSING CARE	149,304	523,484
3 PHYSICAL THERAPY		
4 OCCUPATIONAL THERAPY		
5 SPEECH PATHOLOGY		
6 MEDICAL SOCIAL SERVICES		
7 HOME HEALTH AIDE		
8 SUPPLIES	16,144	56,604
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)	165,448	580,088
21 UNIT COST MULTIPLIER	0.399016	

- (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 )	NEW CAP REL COSTS-MVBLE ( SQUARE FEET )	EMPLOYEE BEN EFITS ( GROSS SALARIES )	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL ( ACCUM. COST )	MAINTENANCE & REPAIRS ( SQUARE FEET )
	3	4	5		6	7
1 ADMIN & GENERAL	1,920	1,920	279,325		93,672	1,920
2 SKILLED NURSING CARE					320,915	
3 PHYSICAL THERAPY						
4 OCCUPATIONAL THERAPY						
5 SPEECH PATHOLOGY						
6 MEDICAL SOCIAL SERVICES						
7 HOME HEALTH AIDE						
8 SUPPLIES					34,700	
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)	1,920	1,920	279,325		449,287	1,920
21 COST TO BE ALLOCATED	14,118	11,173	68,381		74,573	25,161
22 UNIT COST MULTIPLIER	7.353125	5.819271	0.244808		0.165981	13.104688

HHA COST CENTER	OPERATION OF PLANT ( SQUARE FEET )	LAUNDRY & LI NEN SERVICE ( POUNDS OF LAUNDRY )	HOUSEKEEPING ( SQUARE FEET )	DIETARY ( MEALS SERVED )	CAFETERIA (PAID HOURS )	NURSING ADMINISTRATION ( DIRECT NRSING HRS )
	8	9	10	11	12	14
1 ADMIN & GENERAL	1,920		1,920			
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)	1,920		1,920			
21 COST TO BE ALLOCATED	17,538		13,529			
22 UNIT COST MULTIPLIER	9.134375		7.046354			

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

FOR FAIRFIELD MEMORIAL HOSPITAL

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

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1311	I FROM 7/ 1/2007	I WORKSHEET H-5
I HHA NO:	I TO 6/30/2008	I PART II
I 14-7612	I	I

HHA 1

MEDICAL RECO	SOCIAL SERVI
RDS & LIBRAR	CE
(GROSS REV	( TIME
)	SPENT )
17	18

HHA COST CENTER

- 1 ADMIN & GENERAL
- 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)
- 21 COST TO BE ALLOCATED
- 22 UNIT COST MULTIPLIER

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1311 I FROM 7/ 1/2007 I WORKSHEET H-6  
 I HHA NO: I TO 6/30/2008 I PARTS I II & III  
 I 14-7612 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
1 SKILLED NURSING	2	523,484	2	523,484	4,516	115.92	1,795
2 PHYSICAL THERAPY	3				957		573
3 OCCUPATIONAL THERAPY	4				22		66
4 SPEECH PATHOLOGY	5				86		7
5 MEDICAL SOCIAL SERVICES	6						
6 HOME HEALTH AIDE SERVICE	7				48		13
7 TOTAL		523,484		523,484	5,629		2,454

-----PROGRAM VISITS----- COST OF SERVICES-----  
 -----PART B----- PART B-----

	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	TOTAL PROGRAM COST
1 SKILLED NURSING	7	8	9	10	11	12
2 PHYSICAL THERAPY	1,685		208,076	195,325		403,401
3 OCCUPATIONAL THERAPY	217					
4 SPEECH PATHOLOGY	18					
5 MEDICAL SOCIAL SERVICES	15					
6 HOME HEALTH AIDE SERVICES	30					
7 TOTAL	1,965		208,076	195,325		403,401

LIMITATION COST COMPUTATION

PATIENT SERVICES	1	2	3	4	PROGRAM COST LIMITS	PROGRAM VISITS PART A
8 SKILLED NURSING	9914				5	6
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-----  
 -----PART B----- PART B-----

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

[ ] 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	56,604		56,604	21,626	2.617405	9,861
16 COST OF DRUGS	9.00						
16.20 COST OF DRUGS	9.20						

	PROGRAM COVERED CHARGES -----PART B-----		-----COST OF SERVICES-----	
	NOT SUBJECT TO DEDUCT & COINSUR 7	SUBJECT TO DEDUCT & COINSUR 8	NOT SUBJECT TO DEDUCT & COINSUR 9	SUBJECT TO DEDUCT & COINSUR 10
15 COST OF MEDICAL SUPPLIES		8,184	25,810	21,421
16 COST OF DRUGS				
16.20 COST OF DRUGS				

PER BENEFICIARY COST LIMITATION:

	MSA NUMBER 1	AMOUNT 2
162 PROGRAM UNDUP 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	.568505			COL 2, LN 2
2 OCCUPATIONAL THERAPY	51				COL 2, LN 3
3 SPEECH PATHOLOGY	52				COL 2, LN 4
4 MEDICAL SUPPLIES CHARGED TO PATIENT	55	.242274			COL 2, LN 15
5 DRUGS CHARGED TO PATIENTS	56	.334268			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	1/1/1998 TO 12/31/1998	PRIOR 1/1/1998	1/1/1998 TO 12/31/1998	
1 PHYSICAL THERAPY			2.01	3	3.01	4	
2 OCCUPATIONAL THERAPY							
3 SPEECH PATHOLOGY							
4 TOTAL (SUM OF LINES 1-3)							

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 2	PART B SUBJECT TO DED & COINS 3
1	1		
1	REASONABLE COST OF SERVICES		
2	TOTAL CHARGES	299,586	247,401
	CUSTOMARY CHARGES		
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
4	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)		
5	RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)		
6	TOTAL CUSTOMARY CHARGES	299,586	247,401
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST	299,586	247,401
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
9	PRIMARY PAYOR AMOUNTS		

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	PART A SERVICES 1	PART B SERVICES 2
10	TOTAL REASONABLE COST	
10.01	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	347,113
10.02	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	7,676
10.03	TOTAL PPS REIMBURSEMENT-LUPA EPISODES	1,283
10.04	TOTAL PPS REIMBURSEMENT-PEP EPISODES	1,250
10.05	TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE	
10.06	TOTAL PPS REIMBURSEMENT-SCIC EPISODES	
10.07	TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	6,001
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	363,323
13	EXCESS REASONABLE COST	209,317
14	SUBTOTAL	363,323
15	COINSURANCE BILLED TO PROGRAM PATIENTS	209,317
16	NET COST	363,323
17	REIMBURSABLE BAD DEBTS	209,317
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	363,323
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	209,317
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION	
21	OTHER ADJUSTMENTS (SPECIFY)	
22	SUBTOTAL	363,323
23	SEQUESTRATION ADJUSTMENT	209,317
24	SUBTOTAL	363,323
25	INTERIM PAYMENTS	363,323
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	209,317
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		363,323		209,317
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		363,323		209,317
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.