

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	I	14-1320	I	FROM 1/ 1/2008	I	--AUDITED --DESK REVIEW	I	/ /
AND SETTLEMENT SUMMARY	I		I	TO 12/31/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
						--FINAL 1-MCR CODE	I	
						00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/22/2009 TIME 14:19

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:  
PARIS COMMUNITY HOSPITAL 14-1320  
FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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ECR ENCRYPTION INFORMATION  
DATE: 5/22/2009 TIME 14:19  
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PI ENCRYPTION INFORMATION  
DATE: 5/22/2009 TIME 14:19  
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\_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	61,200	-79,347		0
3	SWING BED - SNF	0	50,790	0		0
9	RHC	0	0	141,634		0
9 .01	RHC II	0	0	8,267		0
9 .02	RHC III	0	0	4,011		0
100	TOTAL	0	111,990	74,565		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.

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					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 5/22/2009 TIME 13:37

PART I - CERTIFICATION

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PARIS COMMUNITY HOSPITAL 14-1320  
 FOR THE COST REPORTING PERIOD BEGINNING 1/ 1/2008 AND ENDING 12/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

\_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 721 EAST COURT STREET P.O. BOX:  
 1.01 CITY: PARIS STATE: IL ZIP CODE: 61944- COUNTY: EDGAR

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00 HOSPITAL	PARIS COMMUNITY HOSPITAL	14-1320		6/30/2002	N	O	N
04.00 SWING BED - SNF	PARIS COMMUNITY HOSPITAL	14-2320		6/30/2002	N	O	N
14.00 HOSPITAL-BASED RHC	FMC	14-3987		9/24/1994	N	O	N
14.01 HOSPITAL-BASED RHC 2	HATCH	14-3989		1/ 1/1995	N	O	N
14.02 HOSPITAL-BASED RHC 3	FMC	14-3431		2/16/1997	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

18 TYPE OF CONTROL 1 2

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1  
 20 SUBPROVIDER

OTHER INFORMATION

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

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

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

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

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

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

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

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE 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 CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy) / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

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

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

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

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

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

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

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

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

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /  
 26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /  
 27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 6/30/2002

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	0	0.0000	0.0000	
	0.00	0		

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 DR 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 BDTH 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, CDLUMN 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 SUBPRDVIDER (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

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

TITLE XIX INPATIENT SERVICES

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

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

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

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? 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? N 00/00/0000  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?  
 45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?  
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

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

	PART A		PART B		OUTPATIENT	OUTPATIENT	OUTPATIENT
	1	2	3	4	ASC	RADIOLOGY	DIAGNOSTIC
47.00 HOSPITAL	N	N	N	N	N	N	N

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

54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:  
 PREMIUMS: 0  
 PAID LOSSES: 0  
 AND/OR SELF INSURANCE: 0

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N  
 55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. N 0.00 0

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

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

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

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N  
 60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER?

ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORT FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 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 INSTRUCTIONS) 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? 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 CDDE	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

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET S-3  
I I TO 12/31/2008 I PART I

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	25	9,150	46,968.00	3	4	5
2 HMO						1,608	138
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						657	
4 ADULTS & PED-SB NF							3,580
5 TOTAL ADULTS AND PEDS	25	9,150	46,968.00			2,265	3,718
12 TOTAL	25	9,150	46,968.00			2,265	3,718
13 RPCH VISITS							
24 RURAL HEALTH CLINIC						10,021	
24 01 RURAL HEALTH CLINIC 2						371	
24 02 RURAL HEALTH CLINIC 3						118	
25 TOTAL	25						
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 / 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			2,181				
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			657				
4 ADULTS & PED-SB NF			3,580				
5 TOTAL ADULTS AND PEDS			6,418				
12 TOTAL			6,418				
13 RPCH VISITS							
24 RURAL HEALTH CLINIC			46,185				
24 01 RURAL HEALTH CLINIC 2			2,404				
24 02 RURAL HEALTH CLINIC 3			995				
25 TOTAL							
26 OBSERVATION BED DAYS			119			119	
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					439	62	703
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		177.01			439	62	703
13 RPCH VISITS							
24 RURAL HEALTH CLINIC		55.18					
24 01 RURAL HEALTH CLINIC 2		3.01					
24 02 RURAL HEALTH CLINIC 3		1.29					
25 TOTAL		236.49					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 727 EAST COURT STREET  
 1.01 CITY: PARIS STATE: IL ZIP CODE: 61944 COUNTY: EDGAR  
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT AKERMAN		G02385
9.01 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT PHIPPS		D14690
9.02 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT SHEIKH		G86805
9.03 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT SUTTON		
9.04 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT J SHER		
9.05 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT Z SHER		

PHYSICIAN NAME	HOURS OF SUPERVISION
----------------	----------------------

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC			800	1700	800	1700	800	1900	800	1900	800	1900	800	1130

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

TITLE V TITLE XVIII TITLE XIX

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

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



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

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET S-8  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3989 I

RHC 2

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 144 ILLINOIS  
1.01 CITY: CHRISMAN STATE: IL ZIP CODE: 61924 COUNTY: EDGAR  
2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT SHEIKH	

  

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY			
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO		
12 CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14
			800	1200	1330	1930			800	1200	800	1200				

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

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

RHC 3

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 104 BUENA VISTA  
 1.01 CITY: KANSAS STATE: IL ZIP CODE: 61933 COUNTY: EDGAR  
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	AKERMAN	G02385
	PHYSICIAN NAME	HOURS OF SUPERVISION

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

FACILITY HOURS OF OPERATIONS (1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY			
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO		
12 CLINIC	0		1	2	3	4	5	6	7	8	9	10	11	12	13	14
			830	1200					830	1200	1330	1700				

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

TITLE V TITLE XVIII TITLE XIX

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

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

DESCRIPTION

UNCOMPENSATED CARE INFORMATION

1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?

2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04

2.01 IS IT AT THE TIME OF ADMISSION?

2.02 IS IT AT THE TIME OF FIRST BILLING?

2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?

2.04

3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?

4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?

5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?

6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?

7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?

8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01

8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?

9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04

9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?

9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?

9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?

9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?

10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?

11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04

11.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?

11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?

11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?

11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?

12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?

13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?

14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02

14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?

14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?

15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?

16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?

UNCOMPENSATED CARE REVENUES

17 REVENUE FROM UNCOMPENSATED CARE 1,287,998

17.01 GROSS MEDICAID REVENUES 5,616,557

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 6,904,555

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) .532591

25 TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 \* LINE 24)

26 TOTAL SCHIP CHARGES FROM YOUR RECORDS

HOSPITAL UNCOMPENSATED CARE DATA

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET S-10  
 I I TO 12/31/2008 I  
 I I I

DESCRIPTION

27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	5,616,557
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	2,991,328
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	2,991,328

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO:  
I 14-1320  
I

I PERIOD:  
I FROM 1/ 1/2008 I  
I TO 12/31/2008 I  
I PREPARED 5/22/2009 I  
I WORKSHEET A I

COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE
		1	2	3	4	5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		966,431	966,431	249,478	1,215,909
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		759,849	759,849	122,005	881,854
5	0500 EMPLOYEE BENEFITS	97,393	3,687,577	3,784,970	-227,325	3,557,645
6.01	0660 OTHER ADMINISTRATIVE AND GENERAL	1,020,970	2,446,244	3,467,214	-132,934	3,334,280
6.02	0661 ADMITTING	444,595	147,021	591,616	-2,339	589,277
8	0800 OPERATION OF PLANT	318,713	568,205	886,918	-3,544	883,374
9	0900 LAUNDRY & LINEN SERVICE		105,396	105,396		105,396
10	1000 HOUSEKEEPING	181,170	57,989	239,159		239,159
11	1100 DIETARY	330,688	177,017	507,705	-256,503	251,202
12	1200 CAFETERIA				256,503	256,503
14	1400 NURSING ADMINISTRATION	544,647	33,283	577,930		577,930
16	1600 PHARMACY	142,558	877,594	1,020,152	-865,832	154,320
17	1700 MEDICAL RECORDS & LIBRARY	321,029	84,973	406,002		406,002
18	1800 SOCIAL SERVICE		52,185	52,185		52,185
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	1,315,179	88,770	1,403,949	-9,387	1,394,562
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	540,871	369,552	910,423	-259,794	650,629
40	4000 ANESTHESIOLOGY	347,104	253,395	600,499	91,245	691,744
41	4100 RADIOLOGY-DIAGNOSTIC	1,159,980	1,009,639	2,169,619	62,150	2,231,769
44	4400 LABORATORY	602,899	695,957	1,298,856	-464	1,298,392
49	4900 RESPIRATORY THERAPY	161,961	25,510	187,471	-28,006	159,465
50	5000 PHYSICAL THERAPY	597,778	154,881	752,659		752,659
53	5300 ELECTROCARDIOLOGY		55,072	55,072	50,503	105,575
54	5400 ELECTROENCEPHALOGRAPHY		102,090	102,090		102,090
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS				311,011	311,011
56	5600 DRUGS CHARGED TO PATIENTS				938,379	938,379
59	3020 CARDIAC REHAB	81,955	45,888	127,843	-22,861	104,982
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	191,901	71,990	263,891		263,891
61	6100 EMERGENCY	816,308	1,228,158	2,044,466	-1	2,044,465
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	3,053,730	740,507	3,794,237	-21,372	3,772,865
63.51	6311 RURAL HEALTH CLINIC 2	180,470	89,065	269,535	-29,384	240,151
63.52	6312 RURAL HEALTH CLINIC 3	104,116	51,509	155,625	-16,804	138,821
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		193,368	193,368	-193,368	
95	SUBTOTALS	12,556,015	15,139,115	27,695,130	11,356	27,706,486
	NONREIMBURS COST CENTERS					
98	9800 PHYSICIANS' PRIVATE OFFICES	989,318	215,424	1,204,742	-11,356	1,193,386
101	TOTAL	13,545,333	15,354,539	28,899,872	-0-	28,899,872

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET A  
I I TO 12/31/2008 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	-250,384	965,525
4 0400	NEW CAP REL COSTS-MVBLE EQUIP		881,854
5 0500	EMPLOYEE BENEFITS		3,557,645
6.01 0660	OTHER ADMINISTRATIVE AND GENERAL	-118,332	3,215,948
6.02 0661	ADMITTING		589,277
8 0800	OPERATION OF PLANT		883,374
9 0900	LAUNDRY & LINEN SERVICE		105,396
10 1000	HOUSEKEEPING		239,159
11 1100	DIETARY		251,202
12 1200	CAFETERIA	-80,534	175,969
14 1400	NURSING ADMINISTRATION	-6	577,924
16 1600	PHARMACY		154,320
17 1700	MEDICAL RECORDS & LIBRARY	-1,246	404,756
18 1800	SOCIAL SERVICE		52,185
	INPAT ROUTINE SRVC CNTRS		
25 2500	ADULTS & PEDIATRICS		1,394,562
	ANCILLARY SRVC COST CNTRS		
37 3700	OPERATING ROOM		650,629
40 4000	ANESTHESIOLOGY	-660,145	31,599
41 4100	RADIOLOGY-DIAGNOSTIC	-764,849	1,466,920
44 4400	LABORATORY		1,298,392
49 4900	RESPIRATORY THERAPY		159,465
50 5000	PHYSICAL THERAPY	-2,000	750,659
53 5300	ELECTROCARDIOLOGY	-53,710	51,865
54 5400	ELECTROENCEPHALOGRAPHY	-101,305	785
55 5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,705	307,306
56 5600	DRUGS CHARGED TO PATIENTS	-41,974	896,405
59 3020	CARDIAC REHAB	-20,480	84,502
	OUTPAT SERVICE COST CNTRS		
60 6000	CLINIC	-13,347	250,544
61 6100	EMERGENCY	-901,744	1,142,721
62 6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63 4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50 6310	RURAL HEALTH CLINIC	-182,395	3,590,470
63.51 6311	RURAL HEALTH CLINIC 2	-5,180	234,971
63.52 6312	RURAL HEALTH CLINIC 3	-2,663	136,158
	SPEC PURPOSE COST CENTERS		
88 8800	INTEREST EXPENSE		-0-
95	SUBTOTALS	-3,203,999	24,502,487
	NONREIMBURS COST CENTERS		
98 9800	PHYSICIANS' PRIVATE OFFICES	-21,398	1,171,988
101	TOTAL	-3,225,397	25,674,475

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	
6.01	OTHER ADMINISTRATIVE AND GENERAL	0660	OTHER ADMINISTRATIVE AND GENERAL
6.02	ADMITTING	0661	OTHER ADMINISTRATIVE AND GENERAL
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
25	INPAT ROUTINE SRVC C ADULTS & PEDIATRICS	2500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	CARDIAC REHAB	3020	ACUPUNCTURE
	OUTPAT SERVICE COST		
60	CLINIC	6000	
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
63.51	RURAL HEALTH CLINIC 2	6311	RURAL HEALTH CLINIC #####
63.52	RURAL HEALTH CLINIC 3	6312	RURAL HEALTH CLINIC #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO: 141320	PERIOD: FROM 1/ 1/2008 TO 12/31/2008	PREPARED 5/22/2009 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	INCREASE				
	CODE (1)	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1 RENTAL EXPENSE	A	NEW CAP REL COSTS-MVBLE EQUIP	4		122,005
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14 CAFETERIA	B	CAFETERIA	12	167,070	89,433
15 EKG	C	ELECTROCARDIOLOGY	53	27,642	
16					
17 PROPERTY INSURANCE	D	NEW CAP REL COSTS-BLDG & FIXT	3		56,110
18 OXYGEN/PATIENT SUPPLIES	E	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		77,851
19					
20 DRUGS	F	DRUGS CHARGED TO PATIENTS	56		938,379
21					
22 TELEPHONE	H	OTHER ADMINISTRATIVE AND GENERAL	6.01		39,799
23					
24					
25					
26 STRESS TEST	I	ELECTROCARDIOLOGY	53	14,655	8,206
27 MED SUPPLIES	J	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		233,160
28 INTEREST EXPENSE	K	NEW CAP REL COSTS-BLDG & FIXT	3		193,368
29 ANESTHESIA BENEFITS	L	ANESTHESIOLOGY	40		92,628
30 RADIOLOGY BENEFITS	M	RADIOLOGY-DIAGNOSTIC	41		131,991
31 WOUND CARE BENEFITS	N	RADIOLOGY-DIAGNOSTIC	41		2,706
36 TOTAL RECLASSIFICATIONS				209,367	1,985,636

(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: 141320	PERIOD: FROM 1/ 1/2008 TO 12/31/2008	PREPARED 5/22/2009 WORKSHEET A-6
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EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER 6	DECREASE		SALARY 8	OTHER 9	A-7 REF 10
			LINE NO 7				
1 RENTAL EXPENSE	A		6.01			45,549	10
2			6.02			2,339	
3			8			3,544	
4			25			858	
5			37			26,634	
6			40			1,383	
7			44			464	
8			49			2,116	
9			61			1	
10			63.50			5,149	
11			63.51			18,788	
12			63.52			7,092	
13			98			8,088	
14 CAFETERIA	B		11		167,070	89,433	
15 EKG	C		25		8,529		
16			49		19,113		
17 PROPERTY INSURANCE	D		6.01			56,110	11
18 OXYGEN/PATIENT SUPPLIES	E		6.01			71,074	
19			49			6,777	
20 DRUGS	F		16			865,832	
21			41			72,547	
22 TELEPHONE	H		63.50			16,223	
23			63.51			10,596	
24			63.52			9,712	
25			98			3,268	
26 STRESS TEST	I		59		14,655	8,206	
27 MED SUPPLIES	J		37			233,160	
28 INTEREST EXPENSE	K		88			193,368	11
29 ANESTHESIA BENEFITS	L		5			92,628	
30 RADIOLOGY BENEFITS	M		5			131,991	
31 WOUND CARE BENEFITS	N		5			2,706	
36 TOTAL RECLASSIFICATIONS					209,367	1,985,636	

(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
141320	FROM 1/ 1/2008	5/22/2009
	TO 12/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : RENTAL EXPENSE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	122,005
2.00			0
3.00			0
4.00			0
5.00			0
6.00			0
7.00			0
8.00			0
9.00			0
10.00			0
11.00			0
12.00			0
13.00			0
TOTAL RECLASSIFICATIONS FOR CODE A			122,005

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	45,549	
ADMITTING	6.02	2,339	
OPERATION OF PLANT	8	3,544	
ADULTS & PEDIATRICS	25	858	
OPERATING ROOM	37	26,634	
ANESTHESIOLOGY	40	1,383	
LABORATORY	44	464	
RESPIRATORY THERAPY	49	2,116	
EMERGENCY	61	1	
RURAL HEALTH CLINIC	63.50	5,149	
RURAL HEALTH CLINIC 2	63.51	18,788	
RURAL HEALTH CLINIC 3	63.52	7,092	
PHYSICIANS' PRIVATE OFFICES	98	8,088	
		122,005	

RECLASS CODE: B  
EXPLANATION : CAFETERIA

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	256,503
TOTAL RECLASSIFICATIONS FOR CODE B			256,503

DECREASE			
COST CENTER	LINE	AMOUNT	
DIETARY	11	256,503	
		256,503	

RECLASS CODE: C  
EXPLANATION : EKG

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	27,642
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE C			27,642

DECREASE			
COST CENTER	LINE	AMOUNT	
ADULTS & PEDIATRICS	25	8,529	
RESPIRATORY THERAPY	49	19,113	
		27,642	

RECLASS CODE: D  
EXPLANATION : PROPERTY INSURANCE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	56,110
TOTAL RECLASSIFICATIONS FOR CODE D			56,110

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	56,110	
		56,110	

RECLASS CODE: E  
EXPLANATION : OXYGEN/PATIENT SUPPLIES

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	77,851
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE E			77,851

DECREASE			
COST CENTER	LINE	AMOUNT	
OTHER ADMINISTRATIVE AND GENER	6.01	71,074	
RESPIRATORY THERAPY	49	6,777	
		77,851	

RECLASS CODE: F  
EXPLANATION : DRUGS

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	938,379
2.00			0
TOTAL RECLASSIFICATIONS FOR CODE F			938,379

DECREASE			
COST CENTER	LINE	AMOUNT	
PHARMACY	16	865,832	
RADIOLOGY-DIAGNOSTIC	41	72,547	
		938,379	

RECLASS CODE: H  
EXPLANATION : TELEPHONE

INCREASE			
LINE	COST CENTER	LINE	AMOUNT
1.00	OTHER ADMINISTRATIVE AND GENER	6.01	39,799
2.00			0
3.00			0
4.00			0
TOTAL RECLASSIFICATIONS FOR CODE H			39,799

DECREASE			
COST CENTER	LINE	AMOUNT	
RURAL HEALTH CLINIC	63.50	16,223	
RURAL HEALTH CLINIC 2	63.51	10,596	
RURAL HEALTH CLINIC 3	63.52	9,712	
PHYSICIANS' PRIVATE OFFICES	98	3,268	
		39,799	

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141320	FROM 1/ 1/2008	5/22/2009
	TO 12/31/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: I  
EXPLANATION : STRESS TEST

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	22,861	CARDIAC REHAB	59	22,861
TOTAL RECLASSIFICATIONS FOR CODE I		22,861			22,861

RECLASS CODE: J  
EXPLANATION : MED SUPPLIES

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TD PA	233,160	OPERATING ROOM	37	233,160
TOTAL RECLASSIFICATIONS FOR CODE J		233,160			233,160

RECLASS CODE: K  
EXPLANATION : INTEREST EXPENSE

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	193,368	INTEREST EXPENSE	88	193,368
TOTAL RECLASSIFICATIONS FOR CODE K		193,368			193,368

RECLASS CODE: L  
EXPLANATION : ANESTHESIA BENEFITS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ANESTHESIOLOGY	92,628	EMPLOYEE BENEFITS	5	92,628
TOTAL RECLASSIFICATIONS FOR CODE L		92,628			92,628

RECLASS CODE: M  
EXPLANATION : RADIOLOGY BENEFITS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	131,991	EMPLOYEE BENEFITS	5	131,991
TOTAL RECLASSIFICATIONS FOR CODE M		131,991			131,991

RECLASS CODE: N  
EXPLANATION : WOUND CARE BENEFITS

INCREASE			DECREASE		
LINE	COST CENTER	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RADIOLOGY-DIAGNOSTIC	2,706	EMPLOYEE BENEFITS	5	2,706
TOTAL RECLASSIFICATIONS FOR CODE N		2,706			2,706

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1 LAND	34,112					34,112	
2 LAND IMPROVEMENTS	1,676,788	104,098		104,098		1,780,886	
3 BUILDINGS & FIXTURE	9,166,562	9,946,271		9,946,271		19,112,833	
4 BUILDING IMPROVEMEN							
5 FIXED EQUIPMENT	7,998,691	69,836		69,836		8,068,527	
6 MOVABLE EQUIPMENT							
7 SUBTOTAL	18,876,153	10,120,205		10,120,205		28,996,358	
8 RECONCILING ITEMS							
9 TOTAL	18,876,153	10,120,205		10,120,205		28,996,358	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	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	20,927,830		20,927,830	.721740				
4	NEW CAP REL COSTS-MV	8,068,527		8,068,527	.278260				
5	TOTAL	28,996,357		28,996,357	1.000000				

*	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	938,881	-222,834	249,478				965,525
4	NEW CAP REL COSTS-MV	759,849	122,005					881,854
5	TOTAL	1,698,730	-100,829	249,478				1,847,379

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

*	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	966,431						966,431
4	NEW CAP REL COSTS-MV	759,849						759,849
5	TOTAL	1,726,280						1,726,280

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

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	B	-142,571	NEW CAP REL COSTS-BLDG &	3	10
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5 INVESTMENT INCOME-OTHER					
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-26,107	OTHER ADMINISTRATIVE AND	6.01	
7 REFUNDS AND REBATES OF EXPENSES					
8 RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9 TELEPHONE SERVICES					
10 TELEVISION AND RADIO SERVICE					
11 PARKING LOT					
12 PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,077,239			
13 SALE OF SCRAP, WASTE, ETC.	B	-6,156	RADIOLOGY-DIAGNOSTIC	41	
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15 LAUNDRY AND LINEN SERVICE					
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-80,534	CAFETERIA	12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS	B	-80,263	NEW CAP REL COSTS-BLDG &	3	10
18 SALE OF MED AND SURG SUPPLIES	B	-3,705	MEDICAL SUPPLIES CHARGED	55	
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-41,974	DRUGS CHARGED TO PATIENTS	56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS	B	-1,246	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 PHYSICIAN RECRUITING	A	-18,376	OTHER ADMINISTRATIVE AND	6.01	
38 ADVERTISING	A	-48,269	OTHER ADMINISTRATIVE AND	6.01	
39 ADVERTISING	A	-6	NURSING ADMINISTRATION	14	
40 ADVERTISING	A	-35,771	RURAL HEALTH CLINIC	63.50	
41 ADVERTISING	A	-3,899	RURAL HEALTH CLINIC 2	63.51	
42 ADVERTISING	A	-2,133	RURAL HEALTH CLINIC 3	63.52	
43 ADVERTISING	A	-7,201	PHYSICIANS' PRIVATE OFFIC	98	
44 ANESTHESIA	A	-567,517	ANESTHESIOLOGY	40	
45 ANESTHESIA OTHER	A	-92,628	ANESTHESIOLOGY	40	
46 OTHER REVENUE	B	-10,860	OTHER ADMINISTRATIVE AND	6.01	
47 CPR	B	-5,407	OTHER ADMINISTRATIVE AND	6.01	
48 IHA	A	-7,234	OTHER ADMINISTRATIVE AND	6.01	
49 FMC OTHER REVENUE	B	-146,624	RURAL HEALTH CLINIC	63.50	
49.01 FMC OTHER REVENUE	B	-1,281	RURAL HEALTH CLINIC 2	63.51	
49.02 FMC OTHER REVENUE	B	-530	RURAL HEALTH CLINIC 3	63.52	
49.03 FMC OTHER REVENUE	B	-14,197	PHYSICIANS' PRIVATE OFFIC	98	
49.04 AHA	A	-2,079	OTHER ADMINISTRATIVE AND	6.01	
49.05 PT/OT OTHER REVENUE	B	-2,000	PHYSICAL THERAPY	50	
49.06					
49.07 RADIOLOGY	A	-626,702	RADIOLOGY-DIAGNOSTIC	41	
49.08 RADIOLOGY OTHER	A	-131,991	RADIOLOGY-DIAGNOSTIC	41	
49.09 WOUND CARE	A	-10,641	CLINIC	60	
49.10 WOUND CARE OTHER	A	-2,706	CLINIC	60	
49.11 NON-REIMB DEPR	A	-27,550	NEW CAP REL COSTS-BLDG &	3	9
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,225,397			

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET A-8-2  
 I I TO 12/31/2008 I GROUP 1

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 53	EKG	53,710	53,710					
2 54	EEG	101,305	101,305					
3 59	CARDIAC REHAB	29,480	20,480	9,000				
4 61	ER	1,158,275	901,744	256,531				
5								
6								
7								
8								
9								
10								
11								
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13								
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18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	1,342,770	1,077,239	265,531				





COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I NOT A CMS WORKSHEET  
 I I TO 12/31/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6.01	OTHER ADMINISTRATIVE AND GENERAL	-6	ACCUM.	COST	NOT ENTERED
6.02	ADMITTING	7	ACCUM.	COST	ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	10	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	3	SQUARE	FEET	ENTERED
11	DIETARY	11	MEALS	SERVED	ENTERED
12	CAFETERIA	12	FTE'S		ENTERED
14	NURSING ADMINISTRATION	14	NRSNG	FTE'S	ENTERED
16	PHARMACY	16	DRUGS		ENTERED
17	MEDICAL RECORDS & LIBRARY	17	GROSS REV		ENTERED
18	SOCIAL SERVICE	18	PAT DAYS		ENTERED

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG & OSTS-MVBLE E	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	OTHER ADMINIS TRATIVE AND	ADMITTING
	0	3	4	5	6a.00	6.01	6.02
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	965,525	965,525					
004 NEW CAP REL COSTS-MVBLE E	881,854		881,854				
005 EMPLOYEE BENEFITS	3,557,645	1,991	1,818	3,561,454			
006 01 OTHER ADMINISTRATIVE AND	3,215,948	198,789	181,566	288,440	3,884,743	3,884,743	
006 02 ADMITTING	589,277	17,324	15,822	125,605	748,028	133,361	881,389
008 OPERATION OF PLANT	883,374	97,469	89,022	90,042	1,159,907	206,792	
009 LAUNDRY & LINEN SERVICE	105,396	8,239	7,525		121,160	21,601	
010 HOUSEKEEPING	239,159	5,990	5,471	51,183	301,803	53,806	
011 DIETARY	251,202	24,727	22,584	46,225	344,738	61,461	
012 CAFETERIA	175,969	11,842	10,816	47,200	245,827	43,827	
014 NURSING ADMINISTRATION	577,924	10,627	9,706	153,871	752,128	134,092	
016 PHARMACY	154,320	6,697	6,116	40,275	207,408	36,977	
017 MEDICAL RECORDS & LIBRARY	404,756	18,134	16,562	90,696	530,148	94,516	
018 SOCIAL SERVICE	52,185	2,603	2,377		57,165	10,192	
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	1,394,562	121,118	110,622	369,150	1,995,452	355,755	166,380
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	650,629	53,565	48,923	152,805	905,922	161,510	75,535
040 ANESTHESIOLOGY	31,599	1,103	1,008		33,710	6,010	
041 RADIOLOGY-DIAGNOSTIC	1,466,920	49,661	45,357	187,977	1,749,915	311,980	145,906
044 LABORATORY	1,298,392	28,088	25,654	170,329	1,522,463	271,429	126,941
049 RESPIRATORY THERAPY	159,465	4,508	4,117	40,357	208,447	37,163	17,380
050 PHYSICAL THERAPY	750,659	37,957	34,667	168,882	992,165	176,886	82,726
053 ELECTROCARDIOLOGY	51,865	2,206	2,015	11,950	68,036	12,130	5,673
054 ELECTROENCEPHALOGRAPHY	785				785	140	65
055 MEDICAL SUPPLIES CHARGED	307,306				307,306	54,787	25,623
056 DRUGS CHARGED TO PATIENTS	896,405				896,405	159,814	74,741
059 CARDIAC REHAB	84,502	9,265	8,462	19,013	121,242	21,615	10,109
OUTPAT SERVICE COST CNTRS							
060 CLINIC	250,544	25,804	23,568	54,215	354,131	63,136	29,527
061 EMERGENCY	1,142,721	39,336	35,927	230,620	1,448,604	258,261	120,783
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	3,590,470	138,744	126,720	862,721	4,718,655	841,261	
063 51 RURAL HEALTH CLINIC 2	234,971	12,928	11,808	50,986	310,693	55,391	
063 52 RURAL HEALTH CLINIC 3	136,158	6,662	6,085	29,414	178,319	31,791	
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	24,502,487	935,377	854,318	3,281,956	24,165,305	3,615,684	881,389
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	1,171,988	30,148	27,536	279,498	1,509,170	269,059	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	25,674,475	965,525	881,854	3,561,454	25,674,475	3,884,743	881,389

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
004 NEW CAP REL COSTS-MVBLE E							
005 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	1,366,699						
009 LAUNDRY & LINEN SERVICE	17,326	160,087					
010 HOUSEKEEPING	12,596	24,412	392,617				
011 DIETARY	51,995	3,620	15,271	477,085			
012 CAFETERIA	24,901		7,314		321,869		
014 NURSING ADMINISTRATION	22,346		6,563		14,431	929,560	
016 PHARMACY	14,082		4,136		3,376		265,979
017 MEDICAL RECORDS & LIBRARY	38,131		11,199		17,855		
018 SOCIAL SERVICE	5,473		1,607				
025 INPAT ROUTINE SRVC CNTRS							
ADULTS & PEDIATRICS	254,684	48,991	74,802	477,085	50,106	408,801	21
ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	112,635	16,200	33,081		20,171	164,572	916
040 ANESTHESIOLOGY	2,320		681		3,022		
041 RADIOLOGY-DIAGNOSTIC	104,425	12,037	30,670		24,890		1,066
044 LABORATORY	59,063		17,347		26,351		7
049 RESPIRATORY THERAPY	9,478		2,784		5,408		1,343
050 PHYSICAL THERAPY	79,814	21,838	23,442		20,687	168,778	64
053 ELECTROCARDIOLOGY	4,640		1,363		1,127		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							229,188
059 CARDIAC REHAB	19,482		5,722		1,853		39
060 OUTPAT SERVICE COST CNTRS							
CLINIC	54,261		15,937		2,428		
061 EMERGENCY	82,714	26,120	24,293		22,970	187,409	264
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	291,744	6,869	85,687		107,194		25,803
063 51 RURAL HEALTH CLINIC 2	27,185		7,984				1,465
063 52 RURAL HEALTH CLINIC 3	14,009		4,115				606
095 SUBTOTALS	1,303,304	160,087	373,998	477,085	321,869	929,560	260,782
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	63,395		18,619				5,197
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	1,366,699	160,087	392,617	477,085	321,869	929,560	265,979

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET B  
 I I TO 12/31/2008 I PART I

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	17	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					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	691,849				
018 SOCIAL SERVICE		74,437			
025 INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS	37,720	74,437	3,944,234		3,944,234
ANCILLARY SRVC COST CNTRS					
037 OPERATING ROOM	56,140		1,546,682		1,546,682
040 ANESTHESIOLOGY	7,254		52,997		52,997
041 RADIOLOGY-DIAGNOSTIC	197,358		2,578,247		2,578,247
044 LABORATORY	148,791		2,172,392		2,172,392
049 RESPIRATORY THERAPY	9,378		291,381		291,381
050 PHYSICAL THERAPY	60,098		1,626,498		1,626,498
053 ELECTROCARDIOLOGY	15,336		108,305		108,305
054 ELECTROENCEPHALOGRAPHY	4,655		5,645		5,645
055 MEDICAL SUPPLIES CHARGED	25,094		412,810		412,810
056 DRUGS CHARGED TO PATIENTS	71,052		1,431,200		1,431,200
059 CARDIAC REHAB	2,796		182,858		182,858
060 OUTPAT SERVICE COST CNTRS					
CLINIC	5,579		524,999		524,999
061 EMERGENCY	50,598		2,222,016		2,222,016
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			6,077,213		6,077,213
063 51 RURAL HEALTH CLINIC 2			402,718		402,718
063 52 RURAL HEALTH CLINIC 3			228,840		228,840
SPEC PURPOSE COST CENTERS					
095 SUBTOTALS	691,849	74,437	23,809,035		23,809,035
NONREIMBURS COST CENTERS					
098 PHYSICIANS' PRIVATE OFFIC			1,865,440		1,865,440
101 CROSS FOOT ADJUSTMENT					
102 NEGATIVE COST CENTER					
103 TOTAL	691,849	74,437	25,674,475		25,674,475

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET B  
 I I TO 12/31/2008 I PART III

	COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENE FITS	OTHER ADMINIS TRATIVE AND	ADMITTING
		0	3	4	4a	5	6.01	6.02
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		1,991	1,818	3,809	3,809		
006	01 OTHER ADMINISTRATIVE AND		198,789	181,566	380,355	308	380,663	
006	02 ADMITTING		17,324	15,822	33,146	134	13,068	46,348
008	OPERATION OF PLANT		97,469	89,022	186,491	96	20,264	
009	LAUNDRY & LINEN SERVICE		8,239	7,525	15,764		2,117	
010	HOUSEKEEPING		5,990	5,471	11,461	55	5,272	
011	DIETARY		24,727	22,584	47,311	49	6,023	
012	CAFETERIA		11,842	10,816	22,658	50	4,295	
014	NURSING ADMINISTRATION		10,627	9,706	20,333	164	13,140	
016	PHARMACY		6,697	6,116	12,813	43	3,623	
017	MEDICAL RECORDS & LIBRARY		18,134	16,562	34,696	97	9,262	
018	SOCIAL SERVICE		2,603	2,377	4,980		999	
025	INPAT ROUTINE SRVC CNTRS							
	ADULTS & PEDIATRICS		121,118	110,622	231,740	395	34,861	8,745
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		53,565	48,923	102,488	163	15,826	3,972
040	ANESTHESIOLOGY		1,103	1,008	2,111		589	
041	RADIOLOGY-DIAGNOSTIC		49,661	45,357	95,018	201	30,571	7,673
044	LABORATORY		28,088	25,654	53,742	182	26,597	6,676
049	RESPIRATORY THERAPY		4,508	4,117	8,625	43	3,642	914
050	PHYSICAL THERAPY		37,957	34,667	72,624	181	17,333	4,351
053	ELECTROCARDIOLOGY		2,206	2,015	4,221	13	1,189	298
054	ELECTROENCEPHALOGRAPHY						14	3
055	MEDICAL SUPPLIES CHARGED						5,369	1,348
056	DRUGS CHARGED TO PATIENTS						15,660	3,931
059	CARDIAC REHAB		9,265	8,462	17,727	20	2,118	532
	OUTPAT SERVICE COST CNTRS							
060	CLINIC		25,804	23,568	49,372	58	6,187	1,553
061	EMERGENCY		39,336	35,927	75,263	247	25,307	6,352
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063	50 RURAL HEALTH CLINIC		138,744	126,720	265,464	925	82,429	
063	51 RURAL HEALTH CLINIC 2		12,928	11,808	24,736	55	5,428	
063	52 RURAL HEALTH CLINIC 3		6,662	6,085	12,747	31	3,115	
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		935,377	854,318	1,789,695	3,510	354,298	46,348
	NONREIMBURS COST CENTERS							
098	PHYSICIANS' PRIVATE OFFIC		30,148	27,536	57,684	299	26,365	
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		965,525	881,854	1,847,379	3,809	380,663	46,348

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET B  
 I I TO 12/31/2008 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
	8	9	10	11	12	14	16
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
006 01 OTHER ADMINISTRATIVE AND							
006 02 ADMITTING							
008 OPERATION OF PLANT	206,851						
009 LAUNDRY & LINEN SERVICE	2,622	20,503					
010 HOUSEKEEPING	1,906	3,127	21,821				
011 DIETARY	7,870	464	849	62,566			
012 CAFETERIA	3,769		406		31,178		
014 NURSING ADMINISTRATION	3,382		365		1,398	38,782	
016 PHARMACY	2,131		230		327		19,167
017 MEDICAL RECORDS & LIBRARY	5,771		622		1,730		
018 SOCIAL SERVICE	828		89				
025 INPAT ROUTINE SRVC CNTRS							
025 ADULTS & PEDIATRICS	38,547	6,273	4,157	62,566	4,854	17,055	2
025 ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM	17,047	2,075	1,839		1,954	6,866	66
040 ANESTHESIOLOGY	351		38		293		
041 RADIOLOGY-DIAGNOSTIC	15,805	1,542	1,705		2,411		77
044 LABORATORY	8,939		964		2,552		1
049 RESPIRATORY THERAPY	1,435		155		524		97
050 PHYSICAL THERAPY	12,080	2,797	1,303		2,004	7,042	5
053 ELECTROCARDIOLOGY	702		76		109		
054 ELECTROENCEPHALOGRAPHY							
055 MEDICAL SUPPLIES CHARGED							
056 DRUGS CHARGED TO PATIENTS							16,513
059 CARDIAC REHAB	2,949		318		179		3
060 OUTPAT SERVICE COST CNTRS							
060 CLINIC	8,212		886		235		
061 EMERGENCY	12,519	3,345	1,350		2,225	7,819	19
062 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	44,157	880	4,761		10,383		1,859
063 51 RURAL HEALTH CLINIC 2	4,114		444				106
063 52 RURAL HEALTH CLINIC 3	2,120		229				44
SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	197,256	20,503	20,786	62,566	31,178	38,782	18,792
NONREIMBURS COST CENTERS							
098 PHYSICIANS' PRIVATE OFFIC	9,595		1,035				375
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL	206,851	20,503	21,821	62,566	31,178	38,782	19,167

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1320 I PERIOD: FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/22/2009 I WORKSHEET B I PART III

COST CENTER DESCRIPTION	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVIC E	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	17	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					
006 01 OTHER ADMINISTRATIVE AND					
006 02 ADMITTING					
008 OPERATION OF PLANT					
009 LAUNDRY & LINEN SERVICE					
010 HOUSEKEEPING					
011 DIETARY					
012 CAFETERIA					
014 NURSING ADMINISTRATION					
016 PHARMACY					
017 MEDICAL RECORDS & LIBRARY	52,178				
018 SOCIAL SERVICE		6,896			
025 INPAT ROUTINE SRVC CNTRS					
ADULTS & PEDIATRICS	2,845	6,896	418,936		418,936
037 ANCILLARY SRVC COST CNTRS					
OPERATING ROOM	4,235		156,531		156,531
040 ANESTHESIOLOGY	547		3,929		3,929
041 RADIOLOGY-DIAGNOSTIC	14,877		169,880		169,880
044 LABORATORY	11,224		110,877		110,877
049 RESPIRATORY THERAPY	707		16,142		16,142
050 PHYSICAL THERAPY	4,533		124,253		124,253
053 ELECTROCARDIOLOGY	1,157		7,765		7,765
054 ELECTROENCEPHALOGRAPHY	351		368		368
055 MEDICAL SUPPLIES CHARGED	1,893		8,610		8,610
056 DRUGS CHARGED TO PATIENTS	5,360		41,464		41,464
059 CARDIAC REHAB	211		24,057		24,057
060 OUTPAT SERVICE COST CNTRS					
CLINIC	421		66,924		66,924
061 EMERGENCY	3,817		138,263		138,263
062 OBSERVATION BEDS (NON-DIS					
063 OTHER OUTPATIENT SERVICE					
063 50 RURAL HEALTH CLINIC			410,858		410,858
063 51 RURAL HEALTH CLINIC 2			34,883		34,883
063 52 RURAL HEALTH CLINIC 3			18,286		18,286
095 SPEC PURPOSE COST CENTERS					
SUBTOTALS	52,178	6,896	1,752,026		1,752,026
098 NONREIMBURS COST CENTERS					
PHYSICIANS' PRIVATE OFFIC			95,353		95,353
101 CROSS FOOT ADJUSTMENTS					
102 NEGATIVE COST CENTER					
103 TOTAL	52,178	6,896	1,847,379		1,847,379

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	RECONCILIATION	OTHER ADMINIS	ADMITTING	CO
	OSTS-BLDG & FEET	OSTS-MVBLE E FEET	( GROSS SALARIES )		TRATIVE AND ( ACCUM. COST )	( ACCUM. )ST	
	3	4	5	6a.01	6.01	6.02	
003 GENERAL SERVICE COST							
004 NEW CAP REL COSTS-BLD	112,027						
005 NEW CAP REL COSTS-MVB		112,027					
006 EMPLOYEE BENEFITS	231	231	12,606,223				
006 01 OTHER ADMINISTRATIVE	23,065	23,065	1,020,970	-3,884,743	21,789,732		
006 02 ADMITTING	2,010	2,010	444,595		748,028	10,570,873	
008 OPERATION OF PLANT	11,309	11,309	318,713		1,159,907		
009 LAUNDRY & LINEN SERVI	956	956			121,160		
010 HOUSEKEEPING	695	695	181,170		301,803		
011 DIETARY	2,869	2,869	163,618		344,738		
012 CAFETERIA	1,374	1,374	167,070		245,827		
014 NURSING ADMINISTRATIO	1,233	1,233	544,647		752,128		
016 PHARMACY	777	777	142,558		207,408		
017 MEDICAL RECORDS & LIB	2,104	2,104	321,029		530,148		
018 SOCIAL SERVICE	302	302			57,165		
025 INPAT ROUTINE SRVC CN							
ADULTS & PEDIATRICS	14,053	14,053	1,306,650		1,995,452	1,995,452	
037 ANCILLARY SRVC COST C							
OPERATING ROOM	6,215	6,215	540,871		905,922	905,922	
040 ANESTHESIOLOGY	128	128			33,710		
041 RADIOLOGY-DIAGNOSTIC	5,762	5,762	665,367		1,749,915	1,749,915	
044 LABORATORY	3,259	3,259	602,899		1,522,463	1,522,463	
049 RESPIRATORY THERAPY	523	523	142,848		208,447	208,447	
050 PHYSICAL THERAPY	4,404	4,404	597,778		992,165	992,165	
053 ELECTROCARDIOLOGY	256	256	42,297		68,036	68,036	
054 ELECTROENCEPHALOGRAPH					785	785	
055 MEDICAL SUPPLIES CHAR					307,306	307,306	
056 DRUGS CHARGED TO PATI					896,405	896,405	
059 CARDIAC REHAB	1,075	1,075	67,300		121,242	121,242	
060 OUTPAT SERVICE COST C							
CLINIC	2,994	2,994	191,901		354,131	354,131	
061 EMERGENCY	4,564	4,564	816,308		1,448,604	1,448,604	
062 OBSERVATION BEDS (NON							
063 OTHER OUTPATIENT SERV							
063 50 RURAL HEALTH CLINIC	16,098	16,098	3,053,730		4,718,655		
063 51 RURAL HEALTH CLINIC 2	1,500	1,500	180,470		310,693		
063 52 RURAL HEALTH CLINIC 3	773	773	104,116		178,319		
095 SPEC PURPOSE COST CEN							
SUBTOTALS	108,529	108,529	11,616,905	-3,884,743	20,280,562	10,570,873	
098 NONREIMBURS COST CENT							
PHYSICIANS' PRIVATE O	3,498	3,498	989,318		1,509,170		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 COST TO BE ALLOCATED	965,525	881,854	3,561,454		3,884,743	881,389	
(WRKSHT B, PART I)							
104 UNIT COST MULTIPLIER	8.618681		.282516		.178283		
(WRKSHT B, PT I)		7.871799				.083379	
105 COST TO BE ALLOCATED							
(WRKSHT B, PART II)							
106 UNIT COST MULTIPLIER							
(WRKSHT B, PT II)							
107 COST TO BE ALLOCATED			3,809		380,663	46,348	
(WRKSHT B, PART III)							
108 UNIT COST MULTIPLIER			.000302		.017470		.004385
(WRKSHT B, PT III)							



	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY
		(SQUARE FEET)	(POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)	(FTE'S)	(NRSNG FTE'S)	(DRUGS)
		8	9	10	11	12	14	16
003	GENERAL SERVICE COST							
004	NEW CAP REL COSTS-BLD							
005	NEW CAP REL COSTS-MVB							
006	EMPLOYEE BENEFITS							
006	01 OTHER ADMINISTRATIVE							
006	02 ADMITTING							
008	OPERATION OF PLANT	75,412						
009	LAUNDRY & LINEN SERVI	956	24,191					
010	HOUSEKEEPING	695	3,689	73,761				
011	DIETARY	2,869	547	2,869	100			
012	CAFETERIA	1,374		1,374		344,636		
014	NURSING ADMINISTRATIO	1,233		1,233		15,452	121,993	
016	PHARMACY	777		777		3,615		1,004,826
017	MEDICAL RECORDS & LIB	2,104		2,104		19,118		
018	SOCIAL SERVICE	302		302				
025	INPAT ROUTINE SRVC CN							
	ADULTS & PEDIATRICS	14,053	7,403	14,053	100	53,650	53,650	80
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,215	2,448	6,215		21,598	21,598	3,461
040	ANESTHESIOLOGY	128		128		3,236		
041	RADIOLOGY-DIAGNOSTIC	5,762	1,819	5,762		26,651		4,028
044	LABORATORY	3,259		3,259		28,215		27
049	RESPIRATORY THERAPY	523		523		5,790		5,074
050	PHYSICAL THERAPY	4,404	3,300	4,404		22,150	22,150	243
053	ELECTROCARDIOLOGY	256		256		1,207		
054	ELECTROENCEPHALOGRAPH							
055	MEDICAL SUPPLIES CHAR							
056	DRUGS CHARGED TO PATI							865,832
059	CARDIAC REHAB	1,075		1,075		1,984		149
	OUTPAT SERVICE COST C							
060	CLINIC	2,994		2,994		2,600		
061	EMERGENCY	4,564	3,947	4,564		24,595	24,595	996
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	16,098	1,038	16,098		114,775		97,478
063	51 RURAL HEALTH CLINIC 2	1,500		1,500				5,535
063	52 RURAL HEALTH CLINIC 3	773		773				2,288
095	SUBTOTALS	71,914	24,191	70,263	100	344,636	121,993	985,191
098	NONREIMBURS COST CENT							
	PHYSICIANS' PRIVATE O	3,498		3,498				19,635
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	1,366,699	160,087	392,617	477,085	321,869	929,560	265,979
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		6.617626		4,770.850000		7.619781	
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED	18.123097		5.322826		.933939		.264702
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	206,851	20,503	21,821	62,566	31,178	38,782	19,167
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		.847547		625.660000		.317903	
	(WRKSHT B, PT III)			.295834		.090466		.019075

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET B-1  
 I I TO 12/31/2008 I

COST CENTER MEDICAL RECOR SOCIAL SERVIC  
 DESCRIPTION DS & LIBRARY E  
 (GROSS REV (PAT DAYS  
 ) )

	17	18
GENERAL SERVICE COST		
003 NEW CAP REL COSTS-BLD		
004 NEW CAP REL COSTS-MVB		
005 EMPLOYEE BENEFITS		
006 01 OTHER ADMINISTRATIVE		
006 02 ADMITTING		
008 OPERATION OF PLANT		
009 LAUNDRY & LINEN SERVI		
010 HOUSEKEEPING		
011 DIETARY		
012 CAFETERIA		
014 NURSING ADMINISTRATIO		
016 PHARMACY		
017 MEDICAL RECORDS & LIB	39,416,653	
018 SOCIAL SERVICE		100
INPAT ROUTINE SRVC CN		
025 ADULTS & PEDIATRICS	2,149,055	100
ANCILLARY SRVC COST C		
037 OPERATING ROOM	3,198,521	
040 ANESTHESIOLOGY	413,288	
041 RADIOLOGY-DIAGNOSTIC	11,243,667	
044 LABORATORY	8,477,156	
049 RESPIRATORY THERAPY	534,293	
050 PHYSICAL THERAPY	3,424,008	
053 ELECTROCARDIOLOGY	873,738	
054 ELECTROENCEPHALOGRAPH	265,219	
055 MEDICAL SUPPLIES CHAR	1,429,676	
056 DRUGS CHARGED TO PATI	4,048,114	
059 CARDIAC REHAB	159,273	
OUTPAT SERVICE COST C		
060 CLINIC	317,879	
061 EMERGENCY	2,882,766	
062 OBSERVATION BEDS (NON		
063 OTHER OUTPATIENT SERV		
063 50 RURAL HEALTH CLINIC		
063 51 RURAL HEALTH CLINIC 2		
063 52 RURAL HEALTH CLINIC 3		
SPEC PURPOSE COST CEN		
095 SUBTOTALS	39,416,653	100
NONREIMBURS COST CENT		
098 PHYSICIANS' PRIVATE O		
101 CROSS FOOT ADJUSTMENT		
102 NEGATIVE COST CENTER		
103 COST TO BE ALLOCATED	691,849	74,437
(PER WRKSHT B, PART		
104 UNIT COST MULTIPLIER		744.370000
(WRKSHT B, PT I)	.017552	
105 COST TO BE ALLOCATED		
(PER WRKSHT B, PART		
106 UNIT COST MULTIPLIER		
(WRKSHT B, PT II)		
107 COST TO BE ALLOCATED	52,178	6,896
(PER WRKSHT B, PART		
108 UNIT COST MULTIPLIER		68.960000
(WRKSHT B, PT III)	.001324	

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET C  
 I I TO 12/31/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	3,944,234		3,944,234		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,546,682		1,546,682		
40	ANESTHESIOLOGY	52,997		52,997		
41	RADIOLOGY-DIAGNOSTIC	2,578,247		2,578,247		
44	LABORATORY	2,172,392		2,172,392		
49	RESPIRATORY THERAPY	291,381		291,381		
50	PHYSICAL THERAPY	1,626,498		1,626,498		
53	ELECTROCARDIOLOGY	108,305		108,305		
54	ELECTROENCEPHALOGRAPHY	5,645		5,645		
55	MEDICAL SUPPLIES CHARGED	412,810		412,810		
56	DRUGS CHARGED TO PATIENTS	1,431,200		1,431,200		
59	CARDIAC REHAB	182,858		182,858		
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	524,999		524,999		
61	EMERGENCY	2,222,016		2,222,016		
62	OBSERVATION BEDS (NON-DIS	144,526		144,526		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,077,213		6,077,213		
63	51 RURAL HEALTH CLINIC 2	402,718		402,718		
63	52 RURAL HEALTH CLINIC 3	228,840		228,840		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,953,561		23,953,561		
102	LESS OBSERVATION BEDS	144,526		144,526		
103	TOTAL	23,809,035		23,809,035		

COMPUTATION OF RATIO OF COSTS TO CHARGES

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	2,039,634		2,039,634			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	346,580	2,851,941	3,198,521	.483562	.483562	
40	ANESTHESIOLOGY	60,681	352,606	413,287	.128233	.128233	
41	RADIOLOGY-DIAGNOSTIC	741,023	10,502,645	11,243,668	.229307	.229307	
44	LABORATORY	730,622	7,746,534	8,477,156	.256264	.256264	
49	RESPIRATORY THERAPY	159,797	127,320	287,117	1.014851	1.014851	
50	PHYSICAL THERAPY	378,065	3,045,944	3,424,009	.475027	.475027	
53	ELECTROCARDIOLOGY	72,803	800,935	873,738	.123956	.123956	
54	ELECTROENCEPHALOGRAPHY	1,348	263,872	265,220	.021284	.021284	
55	MEDICAL SUPPLIES CHARGED	408,829	1,268,023	1,676,852	.246182	.246182	
56	DRUGS CHARGED TO PATIENTS	1,146,566	2,901,548	4,048,114	.353547	.353547	
59	CARDIAC REHAB		159,273	159,273	1.148079	1.148079	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	695	317,183	317,878	1.651574	1.651574	
61	EMERGENCY	63,453	2,819,313	2,882,766	.770793	.770793	
62	OBSERVATION BEDS (NON-DIS	13,689	96,932	110,621	1.306497	1.306497	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		4,938,035	4,938,035	1.230695	1.230695	
63	51 RURAL HEALTH CLINIC 2		249,931	249,931	1.611317	1.611317	
63	52 RURAL HEALTH CLINIC 3		98,356	98,356	2.326650	2.326650	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,163,785	38,540,391	44,704,176			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,163,785	38,540,391	44,704,176			

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	3,944,234		3,944,234		
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	1,546,682		1,546,682		
40	ANESTHESIOLOGY	52,997		52,997		
41	RADIOLOGY-DIAGNOSTIC	2,578,247		2,578,247		
44	LABORATORY	2,172,392		2,172,392		
49	RESPIRATORY THERAPY	291,381		291,381		
50	PHYSICAL THERAPY	1,626,498		1,626,498		
53	ELECTROCARDIOLOGY	108,305		108,305		
54	ELECTROENCEPHALOGRAPHY	5,645		5,645		
55	MEDICAL SUPPLIES CHARGED	412,810		412,810		
56	DRUGS CHARGED TO PATIENTS	1,431,200		1,431,200		
59	CARDIAC REHAB OUTPAT SERVICE COST CNTRS	182,858		182,858		
60	CLINIC	524,999		524,999		
61	EMERGENCY	2,222,016		2,222,016		
62	OBSERVATION BEDS (NON-DIS	144,526		144,526		
63	OTHER OUTPATIENT SERVICE					
63	50 RURAL HEALTH CLINIC	6,077,213		6,077,213		
63	51 RURAL HEALTH CLINIC 2	402,718		402,718		
63	52 RURAL HEALTH CLINIC 3	228,840		228,840		
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,953,561		23,953,561		
102	LESS OBSERVATION BEDS	144,526		144,526		
103	TOTAL	23,809,035		23,809,035		

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET C  
I I TO 12/31/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,039,634		2,039,634			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	346,580	2,851,941	3,198,521	.483562	.483562	
40	ANESTHESIOLOGY	60,681	352,606	413,287	.128233	.128233	
41	RADIOLOGY-DIAGNOSTIC	741,023	10,502,645	11,243,668	.229307	.229307	
44	LABORATORY	730,622	7,746,534	8,477,156	.256264	.256264	
49	RESPIRATORY THERAPY	159,797	127,320	287,117	1.014851	1.014851	
50	PHYSICAL THERAPY	378,065	3,045,944	3,424,009	.475027	.475027	
53	ELECTROCARDIOLOGY	72,803	800,935	873,738	.123956	.123956	
54	ELECTROENCEPHALOGRAPHY	1,348	263,872	265,220	.021284	.021284	
55	MEDICAL SUPPLIES CHARGED	408,829	1,268,023	1,676,852	.246182	.246182	
56	DRUGS CHARGED TO PATIENTS	1,146,566	2,901,548	4,048,114	.353547	.353547	
59	CARDIAC REHAB		159,273	159,273	1.148079	1.148079	
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	695	317,183	317,878	1.651574	1.651574	
61	EMERGENCY	63,453	2,819,313	2,882,766	.770793	.770793	
62	OBSERVATION BEDS (NON-DIS	13,689	96,932	110,621	1.306497	1.306497	
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		4,938,035	4,938,035	1.230695	1.230695	
63	51 RURAL HEALTH CLINIC 2		249,931	249,931	1.611317	1.611317	
63	52 RURAL HEALTH CLINIC 3		98,356	98,356	2.326650	2.326650	
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	6,163,785	38,540,391	44,704,176			
102	LESS OBSERVATION BEDS						
103	TOTAL	6,163,785	38,540,391	44,704,176			

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						
37	OPERATING ROOM	1,546,682	156,531	1,390,151			1,546,682
40	ANESTHESIOLOGY	52,997	3,929	49,068			52,997
41	RADIOLOGY-DIAGNOSTIC	2,578,247	169,880	2,408,367			2,578,247
44	LABORATORY	2,172,392	110,877	2,061,515			2,172,392
49	RESPIRATORY THERAPY	291,381	16,142	275,239			291,381
50	PHYSICAL THERAPY	1,626,498	124,253	1,502,245			1,626,498
53	ELECTROCARDIOLOGY	108,305	7,765	100,540			108,305
54	ELECTROENCEPHALOGRAPHY	5,645	368	5,277			5,645
55	MEDICAL SUPPLIES CHARGED	412,810	8,610	404,200			412,810
56	DRUGS CHARGED TO PATIENTS	1,431,200	41,464	1,389,736			1,431,200
59	CARDIAC REHAB	182,858	24,057	158,801			182,858
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	524,999	66,924	458,075			524,999
61	EMERGENCY	2,222,016	138,263	2,083,753			2,222,016
62	OBSERVATION BEDS (NON-DIS	144,526		144,526			144,526
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	6,077,213	410,858	5,666,355			6,077,213
63	51 RURAL HEALTH CLINIC 2	402,718	34,883	367,835			402,718
63	52 RURAL HEALTH CLINIC 3	228,840	18,286	210,554			228,840
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	20,009,327	1,333,090	18,676,237			20,009,327
102	LESS OBSERVATION BEDS	144,526		144,526			144,526
103	TOTAL	19,864,801	1,333,090	18,531,711			19,864,801

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	3,198,521	.483562	.483562
40	ANESTHESIOLOGY	413,287	.128233	.128233
41	RADIOLOGY-DIAGNOSTIC	11,243,668	.229307	.229307
44	LABORATORY	8,477,156	.256264	.256264
49	RESPIRATORY THERAPY	287,117	1.014851	1.014851
50	PHYSICAL THERAPY	3,424,009	.475027	.475027
53	ELECTROCARDIOLOGY	873,738	.123956	.123956
54	ELECTROENCEPHALOGRAPHY	265,220	.021284	.021284
55	MEDICAL SUPPLIES CHARGED	1,676,852	.246182	.246182
56	DRUGS CHARGED TO PATIENTS	4,048,114	.353547	.353547
59	CARDIAC REHAB	159,273	1.148079	1.148079
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	317,878	1.651574	1.651574
61	EMERGENCY	2,882,766	.770793	.770793
62	OBSERVATION BEDS (NON-DIS	110,621	1.306497	1.306497
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	4,938,035	1.230695	1.230695
63 51	RURAL HEALTH CLINIC 2	249,931	1.611317	1.611317
63 52	RURAL HEALTH CLINIC 3	98,356	2.326650	2.326650
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	42,664,542		
102	LESS OBSERVATION BEDS	110,621		
103	TOTAL	42,553,921		



WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						
	OPERATING ROOM	1,546,682	156,531	1,390,151			1,546,682
40	ANESTHESIOLOGY	52,997	3,929	49,068			52,997
41	RADIOLOGY-DIAGNOSTIC	2,578,247	169,880	2,408,367			2,578,247
44	LABORATORY	2,172,392	110,877	2,061,515			2,172,392
49	RESPIRATORY THERAPY	291,381	16,142	275,239			291,381
50	PHYSICAL THERAPY	1,626,498	124,253	1,502,245			1,626,498
53	ELECTROCARDIOLOGY	108,305	7,765	100,540			108,305
54	ELECTROENCEPHALOGRAPHY	5,645	368	5,277			5,645
55	MEDICAL SUPPLIES CHARGED	412,810	8,610	404,200			412,810
56	DRUGS CHARGED TO PATIENTS	1,431,200	41,464	1,389,736			1,431,200
59	CARDIAC REHAB	182,858	24,057	158,801			182,858
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	524,999	66,924	458,075			524,999
61	EMERGENCY	2,222,016	138,263	2,083,753			2,222,016
62	OBSERVATION BEDS (NON-DIS	144,526		144,526			144,526
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC	6,077,213	410,858	5,666,355			6,077,213
63	51 RURAL HEALTH CLINIC 2	402,718	34,883	367,835			402,718
63	52 RURAL HEALTH CLINIC 3	228,840	18,286	210,554			228,840
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	20,009,327	1,333,090	18,676,237			20,009,327
102	LESS OBSERVATION BEDS	144,526		144,526			144,526
103	TOTAL	19,864,801	1,333,090	18,531,711			19,864,801

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRGRATIO	I/P PT B COST TO CHRGRATIO
		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	3,198,521	.483562	.483562
40	ANESTHESIOLOGY	413,287	.128233	.128233
41	RADIOLOGY-DIAGNOSTIC	11,243,668	.229307	.229307
44	LABORATORY	8,477,156	.256264	.256264
49	RESPIRATORY THERAPY	287,117	1.014851	1.014851
50	PHYSICAL THERAPY	3,424,009	.475027	.475027
53	ELECTROCARDIOLOGY	873,738	.123956	.123956
54	ELECTROENCEPHALOGRAPHY	265,220	.021284	.021284
55	MEDICAL SUPPLIES CHARGED	1,676,852	.246182	.246182
56	DRUGS CHARGED TO PATIENTS	4,048,114	.353547	.353547
59	CARDIAC REHAB	159,273	1.148079	1.148079
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	317,878	1.651574	1.651574
61	EMERGENCY	2,882,766	.770793	.770793
62	OBSERVATION BEDS (NON-DIS	110,621	1.306497	1.306497
63	OTHER OUTPATIENT SERVICE			
63	50 RURAL HEALTH CLINIC	4,938,035	1.230695	1.230695
63	51 RURAL HEALTH CLINIC 2	249,931	1.611317	1.611317
63	52 RURAL HEALTH CLINIC 3	98,356	2.326650	2.326650
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	42,664,542		
102	LESS OBSERVATION BEDS	110,621		
103	TOTAL	42,553,921		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

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
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453	11,243,668			
44	LABORATORY	2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925	287,117			
50	PHYSICAL THERAPY	1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539	1,676,852			
56	DRUGS CHARGED TO PATIENTS	1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	159,273			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	515,388	317,878			
61	EMERGENCY	2,180,327	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008	110,621			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	6,008,828	4,938,035			
63 51	RURAL HEALTH CLINIC 2	386,554	249,931			
63 52	RURAL HEALTH CLINIC 3	222,033	98,356			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	19,657,382	42,664,542			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET C  
I I TO 12/31/2008 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
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	1,517,437		1,517,437	3,198,521			
40	ANESTHESIOLOGY	48,718		48,718	413,287			
41	RADIOLOGY-DIAGNOSTIC	2,527,453		2,527,453	11,243,668			
44	LABORATORY	2,129,487		2,129,487	8,477,156			
49	RESPIRATORY THERAPY	285,925		285,925	287,117			
50	PHYSICAL THERAPY	1,595,754		1,595,754	3,424,009			
53	ELECTROCARDIOLOGY	106,113	53,710	159,823	873,738			
54	ELECTROENCEPHALOGRAPHY	5,481	101,305	106,786	265,220			
55	MEDICAL SUPPLIES CHARGED	404,539		404,539	1,676,852			
56	DRUGS CHARGED TO PATIENTS	1,402,901		1,402,901	4,048,114			
59	CARDIAC REHAB	179,436	20,480	199,916	159,273			
	OUTPAT SERVICE COST CNTRS							
60	CLINIC	515,388		515,388	317,878			
61	EMERGENCY	2,180,327	901,744	3,082,071	2,882,766			
62	OBSERVATION BEDS (NON-DIS	141,008		141,008	110,621			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
63 51	RURAL HEALTH CLINIC 2							
63 52	RURAL HEALTH CLINIC 3							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	13,039,967	1,077,239	14,117,206	37,378,220			
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 Radialogy
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.483562		.483562		
40 ANESTHESIOLOGY	.128233		.128233		
41 RADIOLOGY-DIAGNOSTIC	.229307		.229307		
44 LABORATORY	.256264		.256264		
49 RESPIRATORY THERAPY	1.014851		1.014851		
50 PHYSICAL THERAPY	.475027		.475027		
53 ELECTROCARDIOLOGY	.123956		.123956		
54 ELECTROENCEPHALOGRAPHY	.021284		.021284		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.246182		.246182		
56 DRUGS CHARGED TO PATIENTS	.353547		.353547		
59 CARDIAC REHAB	1.148079		1.148079		
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.651574		1.651574		
61 EMERGENCY	.770793		.770793		
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.306497		1.306497		
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
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		928,561			
40 ANESTHESIOLOGY		109,362			
41 RADIOLOGY-DIAGNOSTIC		3,305,214			
44 LABORATORY		2,996,332			
49 RESPIRATORY THERAPY		35,253			
50 PHYSICAL THERAPY		992,744			
53 ELECTROCARDIOLOGY		322,068			
54 ELECTROENCEPHALOGRAPHY		9,962			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		528,632			
56 DRUGS CHARGED TO PATIENTS		1,101,298			
59 CARDIAC REHAB		80,825			
OUTPAT SERVICE COST CNTRS					
60 CLINIC		198,126			
61 EMERGENCY		832,249			
62 OBSERVATION BEDS (NON-DISTINCT PART)		47,710			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL		11,488,336			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		11,488,336			

(A) WORKSHEET A LINE NUMBERS

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

TITLE XVIII, PART B

HOSPITAL

	All Other	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	449,017		
40 ANESTHESIOLOGY	14,024		
41 RADIOLOGY-DIAGNOSTIC	757,909		
44 LABORATORY	767,852		
49 RESPIRATORY THERAPY	35,777		
50 PHYSICAL THERAPY	471,580		
53 ELECTROCARDIOLOGY	39,922		
54 ELECTROENCEPHALOGRAPHY	212		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	130,140		
56 DRUGS CHARGED TO PATIENTS	389,361		
59 CARDIAC REHAB	92,793		
OUTPAT SERVICE COST CNTRS			
60 CLINIC	327,220		
61 EMERGENCY	641,492		
62 OBSERVATION BEDS (NON-DISTINCT PART)	62,333		
63 OTHER OUTPATIENT SERVICE COST CENTER			
63 50 RURAL HEALTH CLINIC			
63 51 RURAL HEALTH CLINIC 2			
63 52 RURAL HEALTH CLINIC 3			
101 SUBTOTAL	4,179,632		
102 CRNA CHARGES			
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104 NET CHARGES	4,179,632		

(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	Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	1	2	3	4	5
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.483562				627,752
40 ANESTHESIOLOGY	.128233				60,867
41 RADIOLOGY-DIAGNOSTIC	.229307				1,892,357
44 LABORATORY	.256264				665,893
49 RESPIRATORY THERAPY	1.014851				15,943
50 PHYSICAL THERAPY	.475027				1,032,609
53 ELECTROCARDIOLOGY	.123956				182,906
54 ELECTROENCEPHALOGRAPHY	.021284				28,709
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	.246182				58,558
56 DRUGS CHARGED TO PATIENTS	.353547				339,370
59 CARDIAC REHAB	1.148079				
OUTPAT SERVICE COST CNTRS					
60 CLINIC	1.651574				4,923
61 EMERGENCY	.770793				379,822
62 OBSERVATION BEDS (NON-DISTINCT PART)	1.306497				14,099
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC	1.230695				
63 51 RURAL HEALTH CLINIC 2	1.611317				
63 52 RURAL HEALTH CLINIC 3	2.326650				
101 SUBTOTAL					5,303,808
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					5,303,808

(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
	5.01	5.02	5.03	6	7
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM					
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC					
44 LABORATORY					
49 RESPIRATORY THERAPY					
50 PHYSICAL THERAPY					
53 ELECTROCARDIOLOGY					
54 ELECTROENCEPHALOGRAPHY					
55 MEDICAL SUPPLIES CHARGED TO PATIENTS					
56 DRUGS CHARGED TO PATIENTS					
59 CARDIAC REHAB					
OUTPAT SERVICE COST CNTRS					
60 CLINIC					
61 EMERGENCY					
62 OBSERVATION BEDS (NON-DISTINCT PART)					
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
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 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		303,557			
40 ANESTHESIOLOGY		7,805			
41 RADIOLOGY-DIAGNOSTIC		433,931			
44 LABORATORY		170,644			
49 RESPIRATORY THERAPY		16,180			
50 PHYSICAL THERAPY		490,517			
53 ELECTROCARDIOLOGY		22,672			
54 ELECTROENCEPHALOGRAPHY		611			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		14,416			
56 DRUGS CHARGED TO PATIENTS		119,983			
59 CARDIAC REHAB					
OUTPAT SERVICE COST CNTRS					
60 CLINIC		8,131			
61 EMERGENCY		292,764			
62 OBSERVATION BEDS (NON-DISTINCT PART)		18,420			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
63 51 RURAL HEALTH CLINIC 2					
63 52 RURAL HEALTH CLINIC 3					
101 SUBTOTAL		1,899,631			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		1,899,631			

(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)	6,537
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,300
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,300
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	657
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	3,580
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)	1,608
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	657
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	98.59
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.59
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,944,234
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	352,952
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	1,150,879
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,793,355

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,052,723
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,052,723
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.360805
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	892.49
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,793,355

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	1,214.50
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,952,916
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT RDUTINE SERVICE COST	1,952,916

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

1  
733,751  
2,686,667

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 CDSTS (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)	797,927
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	797,927
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	119
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,214.50
85	OBSERVATION BED COST	144,526

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: 14-1320 I PERIOD: FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/22/2009 I WORKSHEET D-4 I COMPONENT NO: 14-1320 I OTHER I

TITLE XVIII, PART A HOSPITAL

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,048,162	
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.483562	165,251	79,909
40	ANESTHESIOLOGY	.128233	27,183	3,486
41	RADIOLOGY-DIAGNOSTIC	.229307	383,492	87,937
44	LABORATORY	.256264	429,306	110,016
49	RESPIRATORY THERAPY	1.014851	104,515	106,067
50	PHYSICAL THERAPY	.475027	114,377	54,332
53	ELECTROCARDIOLOGY	.123956	37,450	4,642
54	ELECTROENCEPHALOGRAPHY	.021284	293	6
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.246182	254,842	62,738
56	DRUGS CHARGED TO PATIENTS	.353547	634,401	224,291
59	CARDIAC REHAB	1.148079		
60	OUTPAT SERVICE COST CNTRS CLINIC	1.651574		
61	EMERGENCY	.770793	424	327
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.306497		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		2,151,534	733,751
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,151,534	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-Z320 I I

TITLE XVIII, PART A

SWING BED SNF

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.483562		
40	ANESTHESIOLOGY	.128233		
41	RADIOLOGY-DIAGNOSTIC	.229307	18,931	4,341
44	LABORATORY	.256264	44,203	11,328
49	RESPIRATORY THERAPY	1.014851	17,641	17,903
50	PHYSICAL THERAPY	.475027	215,804	102,513
53	ELECTROCARDIOLOGY	.123956	1,476	183
54	ELECTROENCEPHALOGRAPHY	.021284		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.246182	30,041	7,396
56	DRUGS CHARGED TO PATIENTS	.353547	152,511	53,920
59	CARDIAC REHAB	1.148079		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.651574	174	287
61	EMERGENCY	.770793		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.306497		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63	50 RURAL HEALTH CLINIC			
63	51 RURAL HEALTH CLINIC 2			
63	52 RURAL HEALTH CLINIC 3			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		480,781	197,871
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		480,781	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET D-4  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-1320 I I

TITLE XIX

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 ANCILLARY SRVC COST CNTRS		81,133	
37	OPERATING ROOM	.483562	61,351	29,667
40	ANESTHESIOLOGY	.128233	8,795	1,128
41	RADIOLOGY-DIAGNOSTIC	.229307	78,286	17,952
44	LABORATORY	.256264	45,615	11,689
49	RESPIRATORY THERAPY	1.014851	12,084	12,263
50	PHYSICAL THERAPY	.475027	2,613	1,241
53	ELECTROCARDIOLOGY	.123956	8,283	1,027
54	ELECTROENCEPHALOGRAPHY	.021284		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.246182	7,291	1,795
56	DRUGS CHARGED TO PATIENTS	.353547	67,734	23,947
59	CARDIAC REHAB	1.148079		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	1.651574		
61	EMERGENCY	.770793	11,345	8,745
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.306497	2,654	3,467
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC	1.230695		
63 51	RURAL HEALTH CLINIC 2	1.611317		
63 52	RURAL HEALTH CLINIC 3	2.326650		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		306,051	112,921
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		306,051	



CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET E  
 I COMPONENT NO: I TO 12/31/2008 I PART B  
 I 14-1320 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,179,632
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)	4,179,632
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)	4,221,428
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	CAH DEDUCTIBLES	43,185
18.01	CAH ACTUAL BILLED COINSURANCE	1,701,659
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	2,476,584
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	2,476,584
24	PRIMARY PAYER PAYMENTS	972
25	SUBTOTAL	2,475,612
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	428,964
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	428,964
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	2,904,576
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	2,904,576
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,983,923
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	-79,347
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-1320 I

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.		2,209,425		2,504,760
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)		68,986		373,510
ADJUSTMENTS TO PROVIDER .01	8/12/2008	123,913	8/12/2008	11,096
ADJUSTMENTS TO PROVIDER .02			8/12/2008	94,557
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		123,913		105,653
4 TOTAL INTERIM PAYMENTS		2,402,324		2,983,923
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)		61,200		79,347
7 TOTAL MEDICARE PROGRAM LIABILITY		2,463,524		2,904,576

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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET E-1  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-Z320 I I

TITLE XVIII SWING BED 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		897,027		
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	8/12/2008	50,335	
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		50,335	NONE
4 TOTAL INTERIM PAYMENTS			947,362	
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)			50,790	
7 TOTAL MEDICARE PROGRAM LIABILITY			998,152	

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT  
SWING BEDS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I  
 I COMPONENT NO: I TO 12/31/2008 I WORKSHEET E-2  
 I 14-Z320 I I

TITLE XVIII SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	805,906	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	199,850	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	657	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,005,756	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,005,756	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,005,756	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS) (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	9,216	
14	80% OF PART B COSTS		
15	SUBTOTAL	996,540	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS	1,612	
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	998,152	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	947,362	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	50,790	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/22/2009
I	14-1320	I	FROM 1/ 1/2008	I	WORKSHEET E-3
I	COMPONENT NO:	I	TO 12/31/2008	I	PART II
I	14-1320	I		I	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,686,667
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,686,667
5	PRIMARY PAYER PAYMENTS	3,173
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,710,329

COMPUTATION OF LESSER OF COST OR CHARGES

7	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	2,710,329
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	324,503
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,385,826
23	COINSURANCE	
24	SUBTOTAL	2,385,826
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	77,698
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	77,698
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,463,524
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	2,463,524
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,402,324
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	61,200
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	494,338

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	4,875,075			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	4,442,248			
5	OTHER RECEIVABLES	553,560			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				
7	INVENTORY	551,090			
8	PREPAID EXPENSES	299,145			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS	8,671,717			
11	TOTAL CURRENT ASSETS	19,392,835			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS				
13	LESS ACCUMULATED DEPRECIATION				
13.01	BUILDINGS	15,570,497			
14	LESS ACCUMULATED DEPRECIATION				
14.01	LEASEHOLD IMPROVEMENTS				
15	LESS ACCUMULATED DEPRECIATION				
15.01	FIXED EQUIPMENT				
16	LESS ACCUMULATED DEPRECIATION				
16.01	AUTOMOBILES AND TRUCKS				
17	LESS ACCUMULATED DEPRECIATION				
17.01	MAJOR MOVABLE EQUIPMENT				
18	LESS ACCUMULATED DEPRECIATION				
18.01	MINOR EQUIPMENT DEPRECIABLE				
19	LESS ACCUMULATED DEPRECIATION				
19.01	MINOR EQUIPMENT-NONDEPRECIABLE				
20	TOTAL FIXED ASSETS	15,570,497			
21	OTHER ASSETS				
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	329,433			
26	TOTAL OTHER ASSETS	329,433			
27	TOTAL ASSETS	35,292,765			

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,074,118			
29 SALARIES, WAGES & FEES PAYABLE	1,885,438			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	303,156			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	1,053,400			
35 OTHER CURRENT LIABILITIES				
36 TOTAL CURRENT LIABILITIES	4,316,112			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE	4,714,518			
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	4,714,518			
43 TOTAL LIABILITIES	9,030,630			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	26,262,135			
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	26,262,135			
52 TOTAL LIABILITIES AND FUND BALANCES	35,292,765			

STATEMENT OF CHANGES IN FUND BALANCES

GENERAL FUND

SPECIFIC PURPOSE FUND

	1	2	3	4
1 FUND BALANCE AT BEGINNING OF PERIOD		27,109,659		
2 NET INCOME (LOSS)		-3,487,461		
3 TOTAL		23,622,198		
4 ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
5 ADDITIONS (CREDIT ADJUSTM	2,639,937			
6				
7				
8				
9				
10 TOTAL ADDITIONS		2,639,937		
11 SUBTOTAL		26,262,135		
12 DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
13 DEDUCTIONS (DEBIT ADJUSTM				
14				
15				
16				
17				
18 TOTAL DEDUCTIONS				
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		26,262,135		

ENDOWMENT FUND

PLANT FUND

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



STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO: 14-1320 I PERIOD: 1/ 1/2008 I TO 12/31/2008 I PREPARED 5/22/2009 I WORKSHEET G-2 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
GENERAL INPATIENT ROUTINE CARE SERVICES			
1 00 HOSPITAL	2,052,723		2,052,723
4 00 SWING BED - SNF			
5 00 SWING BED - NF			
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	2,052,723		2,052,723
INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16 00 TOTAL INPATIENT ROUTINE CARE SERVICE	2,052,723		2,052,723
17 00 ANCILLARY SERVICES	4,111,887	33,252,042	37,363,929
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC		5,476,792	5,476,792
18 51 RURAL HEALTH CLINIC 2		249,868	249,868
18 52 RURAL HEALTH CLINIC 3		98,155	98,155
24 00	387,101	7,973,634	8,360,735
25 00 TOTAL PATIENT REVENUES	6,551,711	47,050,491	53,602,202

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		28,899,872	
ADD (SPECIFY)			
27 00 ADD (SPECIFY)	2,773,607		
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS		2,773,607	
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		31,673,479	

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET G-3  
 I I TO 12/31/2008 I

DESCRIPTION

1	TOTAL PATIENT REVENUES	53,602,202
2	LESS: ALLOWANCES AND DISCOUNTS ON	22,213,215
3	NET PATIENT REVENUES	31,388,987
4	LESS: TOTAL OPERATING EXPENSES	31,673,479
5	NET INCOME FROM SERVICE TO PATIENT	-284,492
	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	500,045
24	OTHER (SPECIFY)	
25	TOTAL OTHER INCOME	500,045
26	TOTAL	215,553
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	3,703,014
28		
29		
30	TOTAL OTHER EXPENSES	3,703,014
31	NET INCOME (OR LOSS) FOR THE PERIO	-3,487,461

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3987 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
1 FACILITY HEALTH CARE STAFF COSTS				
1 PHYSICIAN	1,658,741		1,658,741	
2 PHYSICIAN ASSISTANT				
3 NURSE PRACTITIONER	121,259		121,259	
4 VISITING NURSE				
5 OTHER NURSE	586,940		586,940	
6 CLINICAL PSYCHOLOGIST				
7 CLINICAL SOCIAL WORKER				
8 LABORATORY TECHNICIAN				
9 OTHER FACILITY HEALTH CARE STAFF COSTS				
10 SUBTOTAL (SUM OF LINES 1-9)	2,366,940		2,366,940	
11 COSTS UNDER AGREEMENT				
12 PHYSICIAN SERVICES UNDER AGREEMENT				
13 PHYSICIAN SUPERVISION UNDER AGREEMENT				
14 OTHER COSTS UNDER AGREEMENT				
14 SUBTOTAL (SUM OF LINES 11-13)				
15 OTHER HEALTH CARE COSTS				
15 MEDICAL SUPPLIES		4,710	4,710	
16 TRANSPORTATION (HEALTH CARE STAFF)				
17 DEPRECIATION-MEDICAL EQUIPMENT				
18 PROFESSIONAL LIABILITY INSURANCE		157,380	157,380	
19 OTHER HEALTH CARE COSTS				
20 ALLOWABLE GME COSTS				
21 SUBTOTAL (SUM OF LINES 15-20)		162,090	162,090	
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,366,940	162,090	2,529,030	
23 COSTS OTHER THAN RHC/FQHC SERVICES				
23 PHARMACY		116,043	116,043	
24 DENTAL				
25 OPTOMETRY				
26 ALL OTHER NONREIMBURSABLE COSTS		171,061	171,061	
27 NONALLOWABLE GME COSTS				
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		287,104	287,104	
29 FACILITY OVERHEAD				
29 FACILITY COSTS				
30 ADMINISTRATIVE COSTS	686,790	291,313	978,103	-21,372
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	686,790	291,313	978,103	-21,372
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,053,730	740,507	3,794,237	-21,372

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3987 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	1,658,741		1,658,741
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	121,259		121,259
5 VISITING NURSE			
6 OTHER NURSE	586,940		586,940
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	2,366,940		2,366,940
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	4,710		4,710
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	157,380		157,380
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	162,090		162,090
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,529,030		2,529,030
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	116,043		116,043
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS	171,061		171,061
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	287,104		287,104
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	956,731	-182,395	774,336
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	956,731	-182,395	774,336
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,772,865	-182,395	3,590,470

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3989 I I

RHC 2

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	12,000	12,000	
2	PHYSICIAN ASSISTANT			
3	NURSE PRACTITIONER	93,162	93,162	
4	VISITING NURSE			
5	OTHER NURSE	36,309	36,309	
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	141,471	141,471	
COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		222	
16	TRANSPORTATION (HEALTH CARE STAFF)		222	
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE		442	
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)		664	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	141,471	664	142,135
COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY		5,462	
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS		18,772	
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)		24,234	
FACILITY OVERHEAD				
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	38,999	64,167	103,166
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	38,999	64,167	-29,384
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	180,470	89,065	-29,384

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3989 I I

RHC 2

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	12,000		12,000
3 PHYSICIAN ASSISTANT			
4 NURSE PRACTITIONER	93,162		93,162
5 VISITING NURSE			
6 OTHER NURSE	36,309		36,309
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
10 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	141,471		141,471
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
14 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES	222		222
17 TRANSPORTATION (HEALTH CARE STAFF)			
18 DEPRECIATION-MEDICAL EQUIPMENT			
19 PROFESSIONAL LIABILITY INSURANCE	442		442
20 OTHER HEALTH CARE COSTS			
21 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)	664		664
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	142,135		142,135
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY	5,462		5,462
25 DENTAL			
26 OPTOMETRY			
27 ALL OTHER NONREIMBURSABLE COSTS	18,772		18,772
28 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	24,234		24,234
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	73,782	-5,180	68,602
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	73,782	-5,180	68,602
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	240,151	-5,180	234,971

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3431 I I

RHC 3

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	8,004		8,004	
3				
4	58,836		58,836	
5				
6	21,154		21,154	
7				
8				
9				
10	87,994		87,994	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15		82	82	
16				
17				
18		604	604	
19				
20				
21		686	686	
22	87,994	686	88,680	
COSTS OTHER THAN RHC/FQHC SERVICES				
23		2,017	2,017	
24				
25				
26		6,555	6,555	
27				
28		8,572	8,572	
FACILITY OVERHEAD				
29				
30	16,122	42,251	58,373	-16,804
31	16,122	42,251	58,373	-16,804
32	104,116	51,509	155,625	-16,804

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
FEDERALLY QUALIFIED HEALTH CENTER COSTS

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-1  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3431 I I

RHC 3

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	8,004	8,004
2	PHYSICIAN ASSISTANT		
3	NURSE PRACTITIONER	58,836	58,836
4	VISITING NURSE		
5	OTHER NURSE	21,154	21,154
6	CLINICAL PSYCHOLOGIST		
7	CLINICAL SOCIAL WORKER		
8	LABORATORY TECHNICIAN		
9	OTHER FACILITY HEALTH CARE STAFF COSTS		
10	SUBTOTAL (SUM OF LINES 1-9)	87,994	87,994
COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT		
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		
13	OTHER COSTS UNDER AGREEMENT		
14	SUBTOTAL (SUM OF LINES 11-13)		
OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	82	82
16	TRANSPORTATION (HEALTH CARE STAFF)		
17	DEPRECIATION-MEDICAL EQUIPMENT		
18	PROFESSIONAL LIABILITY INSURANCE	604	604
19	OTHER HEALTH CARE COSTS		
20	ALLOWABLE GME COSTS		
21	SUBTOTAL (SUM OF LINES 15-20)	686	686
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	88,680	88,680
COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY	2,017	2,017
24	DENTAL		
25	OPTOMETRY		
26	ALL OTHER NONREIMBURSABLE COSTS	6,555	6,555
27	NONALLOWABLE GME COSTS		
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)	8,572	8,572
FACILITY OVERHEAD			
29	FACILITY COSTS		
30	ADMINISTRATIVE COSTS	41,569	38,906
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	41,569	38,906
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	138,821	136,158



ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-2  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3987 I I

RHC 1

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	4.95	43,640	4,200	20,790
3 PHYSICIAN ASSISTANTS			2,100	
4 NURSE PRACTITIONERS	1.11	2,545	2,100	2,331
5 SUBTOTAL (SUM OF LINES 1-3)	6.06	46,185		23,121
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	6.06	46,185		
PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10 TOTAL COSTS OF HEALTH CARE SERVICES		2,529,030		
(FROM WORKSHEET M-1, COLUMN 7, LINE 22)				
11 TOTAL NONREIMBURSABLE COSTS		287,104		
(FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)		2,816,134		
(SUM OF LINES 10 AND 11)				
13 RATIO OF RHC/FQHC SERVICES		.898050		
(LINE 10 DIVIDED BY LINE 12)				
14 TOTAL FACILITY OVERHEAD		774,336		
(FROM WORKSHEET M-1, COLUMN 7, LINE 31)				
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY		2,486,743		
(SEE INSTRUCTIONS)				
16 TOTAL OVERHEAD		3,261,079		
(SUM OF LINES 14 AND 15)				
17 ALLOWABLE GME OVERHEAD				
(SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16		3,261,079		
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES		2,928,612		
(LINE 13 X LINE 18)				
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES		5,457,642		
(SUM OF LINES 10 AND 19)				

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/22/2009
I	14-1320	I	FROM 1/ 1/2008	I	WORKSHEET M-2
I	COMPONENT NO:	I	TO 12/31/2008	I	
I	14-3987	I		I	

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF  
COL. 2 OR  
COL. 4  
5

	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	46,185
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	46,185
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-2  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3989 I I

RHC 2

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	.01		4,200	42
3 PHYSICIAN ASSISTANTS			2,100	
4 NURSE PRACTITIONERS	.88	2,404	2,100	1,848
5 SUBTOTAL (SUM OF LINES 1-3)	.89	2,404		1,890
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTES AND VISITS (SUM OF LINES 4-7)	.89	2,404		
PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
10 TOTAL COSTS OF HEALTH CARE SERVICES		142,135		
(FROM WORKSHEET M-1, COLUMN 7, LINE 22)				
11 TOTAL NONREIMBURSABLE COSTS		24,234		
(FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)		166,369		
(SUM OF LINES 10 AND 11)				
13 RATIO OF RHC/FQHC SERVICES	.854336			
(LINE 10 DIVIDED BY LINE 12)				
14 TOTAL FACILITY OVERHEAD		68,602		
(FROM WORKSHEET M-1, COLUMN 7, LINE 31)				
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY		167,747		
(SEE INSTRUCTIONS)				
16 TOTAL OVERHEAD		236,349		
(SUM OF LINES 14 AND 15)				
17 ALLOWABLE GME OVERHEAD				
(SEE INSTRUCTIONS)				
18 SUBTRACT LINE 17 FROM LINE 16		236,349		
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES		201,921		
(LINE 13 X LINE 18)				
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES		344,056		
(SUM OF LINES 10 AND 19)				

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/22/2009
I	14-1320	I	FROM 1/ 1/2008	I	WORKSHEET M-2
I	COMPONENT NO:	I	TO 12/31/2008	I	
I	14-3989	I		I	

RHC 2

VISITS AND PRODUCTIVITY

GREATER OF  
COL. 2 OR  
COL. 4  
5

	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	2,404
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	2,404
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

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

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-2  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3431 I I

## RHC 3

## VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRDDUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
1 POSITIONS				
2 PHYSICIANS	.01	29	4,200	42
3 PHYSICIAN ASSISTANTS			2,100	
4 NURSE PRACTITIONERS	.56	966	2,100	1,176
5 SUBTOTAL (SUM DF LINES 1-3)	.57	995		1,218
6 VISITING NURSE				
7 CLINICAL PSYCHOLOGIST				
8 CLINICAL SOCIAL WORKER				
9 TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	.57	995		
10 PHYSICIAN SERVICES UNDER AGREEMENTS				
11 DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
12 TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)		88,680		
13 TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)		8,572		
14 COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)		97,252		
15 RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	.911858			
16 TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)		38,906		
17 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)		92,682		
18 TOTAL OVERHEAD (SUM OF LINES 14 AND 15)		131,588		
19 ALLOWABLE GME DVERHEAD (SEE INSTRUCTIONS)				
20 SUBTRACT LINE 17 FROM LINE 16		131,588		
OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)		119,990		
TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM DF LINES 10 AND 19)		208,670		

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-2  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3431 I I

RHC 3

VISITS AND PRODUCTIVITY

GREATER OF  
COL. 2 OR  
COL. 4  
5

POSITIONS	
1	PHYSICIANS
2	PHYSICIAN ASSISTANTS
3	NURSE PRACTITIONERS
4	SUBTOTAL (SUM OF LINES 1-3) 1,218
5	VISITING NURSE
6	CLINICAL PSYCHOLOGIST
7	CLINICAL SOCIAL WORKER
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7) 1,218
9	PHYSICIAN SERVICES UNDER AGREEMENTS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 FOR RHC/FQHC SERVICES

TITLE XVIII RHC 1

1	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	5,457,642
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	61,058
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	5,396,584
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	46,185
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	46,185
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	116.85

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	116.85
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	10,021
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	1,170,954
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)	
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)	
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)	
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*	1,170,954
16.01	PRIMARY PAYER AMOUNT	354
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	120,288
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	1,050,312
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	840,250
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	38,110
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	878,360
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	44,670
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	
23	OTHER ADJUSTMENTS (SPECIFY)	
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)	923,030
25	INTERIM PAYMENTS	781,396
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	141,634
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2	

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT  
FOR RHC/FQHC SERVICES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED
I	14-1320	I	FROM 1/ 1/2008	I	5/22/2009
I	COMPONENT NO:	I	TO 12/31/2008	I	WORKSHEET M-3
I	14-3989	I		I	

TITLE XVIII RHC 2

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	344,056
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	5,813
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	338,243
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	2,404
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	2,404
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	140.70

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	140.70	140.70
10 CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		371
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		52,200
12 PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13 PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14 LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15 GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16 TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		52,200
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		5,326
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		46,874
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		37,499
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		3,410
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		40,909
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		1,839
22.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23 OTHER ADJUSTMENTS (SPECIFY)		
24 NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		42,748
25 INTERIM PAYMENTS		34,481
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		8,267
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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



CALCULATION OF REIMBURSEMENT SETTLEMENT  
FOR RHC/FQHC SERVICES

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-3  
I COMPONENT NO: I TO 12/31/2008 I  
I 14-3431 I I

TITLE XVIII RHC 3

* FOR DETERMINATION OF RATE FOR RHC/FQHC SERVICES	UCATION PASS THROUGH COST.
1 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	208,670
2 COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	2,765
3 TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	205,905
4 TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	1,218
5 PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6 TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	1,218
7 ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	169.05

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8 PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)		999.00
9 RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	169.05	169.05
10 CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		118
11 PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		19,948
12 PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13 PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14 LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15 GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16 TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		19,948
16.01 PRIMARY PAYER AMOUNT		
17 LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		1,643
18 NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		18,305
19 REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		14,644
20 PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		1,305
21 TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		15,949
22 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		351
22.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23 OTHER ADJUSTMENTS (SPECIFY)		
24 NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		16,300
25 INTERIM PAYMENTS		12,289
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26 BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		4,011
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND  
INFLUENZA VACCINE COST

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 5/22/2009
I	14-1320	I	FROM 1/ 1/2008	I	WORKSHEET M-4
I	COMPONENT NO:	I	TO 12/31/2008	I	
I	14-3987	I		I	

## TITLE XVIII

## RHC 1

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	2,366,940	2,366,940
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000067	.001823
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	159	4,315
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	6,116	16,080
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	6,275	20,395
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	2,529,030	2,529,030
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	3,261,079	3,261,079
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.002481	.008064
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	8,091	26,297
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	14,366	46,692
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	206	1,437
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	69.74	32.49
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	150	851
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	10,461	27,649
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		61,058
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		38,110

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-4  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-3989 I I

TITLE XVIII

RHC 2

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	141,471	141,471
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000049	.000452
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	7	64
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	322	1,790
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	329	1,854
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	142,135	142,135
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	236,349	236,349
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.002315	.013044
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	547	3,083
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	876	4,937
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	11	160
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	79.64	30.86
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	6	95
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	478	2,932
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		5,813
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		3,410

COMPUTATION OF PNEUMOCOCCAL AND  
INFLUENZA VACCINE COST

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-4  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-3431 I I

TITLE XVIII RHC 3

	PNEUMOCOCCAL 1	INFLUENZA 2
1 HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	87,994	87,994
2 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	.000025	.001137
3 PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)	2	100
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)	105	906
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	107	1,006
6 TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	88,680	88,680
7 TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	131,588	131,588
8 RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	.001207	.011344
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)	159	1,493
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)	266	2,499
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	4	81
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)	66.50	30.85
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	38
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)	133	1,172
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		2,765
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		1,305

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

I PROVIDER NO: 14-1320  
 I PERIOD: FROM 1/ 1/2008 TO 12/31/2008  
 I COMPONENT NO: 14-3987  
 I PREPARED 5/22/2009  
 I WORKSHEET M-5  
 I

RHC 1

DESCRIPTION

P A R T B  
 MM/DD/YYYY AMOUNT  
 1 2

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.			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	8/12/2008	41,345
	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		41,345
4	TOTAL INTERIM PAYMENTS			781,396
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			141,634
	SETTLEMENT TO PROVIDER	.01		
	SETTLEMENT TO PROGRAM	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY			923,030

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.

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

I PROVIDER NO: 14-1320  
 I PERIOD: FROM 1/ 1/2008 TO 12/31/2008  
 I COMPONENT NO: 14-3989  
 I PREPARED 5/22/2009  
 I WORKSHEET M-5  
 I

RHC 2

DESCRIPTION	P A R T		B AMOUNT
	MM/DD/YYYY		
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1	2
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
ADJUSTMENTS TO PROVIDER .01	8/12/2008		3,300
ADJUSTMENTS TO PROVIDER .02			
ADJUSTMENTS TO PROVIDER .03			
ADJUSTMENTS TO PROVIDER .04			
ADJUSTMENTS TO PROVIDER .05			
ADJUSTMENTS TO PROGRAM .50			
ADJUSTMENTS TO PROGRAM .51			
ADJUSTMENTS TO PROGRAM .52			
ADJUSTMENTS TO PROGRAM .53			
ADJUSTMENTS TO PROGRAM .54			
SUBTOTAL .99			3,300
4 TOTAL INTERIM PAYMENTS			34,481
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
TENTATIVE TO PROVIDER .01			
TENTATIVE TO PROVIDER .02			
TENTATIVE TO PROVIDER .03			
TENTATIVE TO PROGRAM .50			
TENTATIVE TO PROGRAM .51			
TENTATIVE TO PROGRAM .52			
SUBTOTAL .99			NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			8,267
7 TOTAL MEDICARE PROGRAM LIABILITY			42,748

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.

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

I PROVIDER NO: I PERIOD: I PREPARED 5/22/2009  
 I 14-1320 I FROM 1/ 1/2008 I WORKSHEET M-5  
 I COMPONENT NO: I TO 12/31/2008 I  
 I 14-3431 I

RHC 3

DESCRIPTION

P A R T B  
 MM/DD/YYYY AMOUNT  
 1 2

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				10,122
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.				NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
	ADJUSTMENTS TO PROVIDER	.01	8/12/2008		2,167
	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			2,167
4	TOTAL INTERIM PAYMENTS				12,289
	TO BE COMPLETED BY INTERMEDIARY				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
	TENTATIVE TO PROVIDER	.01			
	TENTATIVE TO PROVIDER	.02			
	TENTATIVE TO PROVIDER	.03			
	TENTATIVE TO PROGRAM	.50			
	TENTATIVE TO PROGRAM	.51			
	TENTATIVE TO PROGRAM	.52			
	SUBTOTAL	.99			NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02			4,011
7	TOTAL MEDICARE PROGRAM LIABILITY				16,300

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.