

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

FORM APPROVED  
OMB NO. 0938-0050

WORKSHEET S  
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I	PERIOD	I	INTERMEDIARY USE ONLY	I	DATE RECEIVED:
COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	I	14-1321	I	FROM 7/ 1/2007	I	--AUDITED --DESK REVIEW	I	/ /
	I		I	TO 6/30/2008	I	--INITIAL --REOPENED	I	INTERMEDIARY NO:
	I		I		I	--FINAL 1-MCR CODE	I	
					I	00 - # OF REOPENINGS	I	

ELECTRONICALLY FILED COST REPORT DATE: 11/21/2008 TIME 10:45

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: FRANKLIN HOSPITAL 14-1321

FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2007 AND ENDING 6/30/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	A	TITLE XVIII	B	TITLE XIX	
	1	2		3	4	
1	HOSPITAL	0	264,908	386,389	0	0
3	SWING BED - SNF	0	10,464	0	0	0
5	HOSPITAL-BASED SNF	0	85,708	0	0	0
9	RHC	0	0	150,129	0	0
100	TOTAL	0	361,080	536,518	0	0

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-2  
 I I TO 6/30/2008 I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 201 BAILEY LANE P.O. BOX:  
 1.01 CITY: BENTON STATE: IL ZIP CODE: 62812- COUNTY: FRANKLIN

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	14-1321		8/ 1/2002	N	O	N
04.00	SWING BED - SNF	14-2321		8/ 1/2002	N	O	N
06.00	HOSPITAL-BASED SNF	14-6088		8/12/2005	N	P	N
14.00	HOSPITAL-BASED RHC	14-3469		7/ 6/2005	N	O	N

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

18 TYPE OF CONTROL

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 TERMINATION IN COL. 3. / /

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

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

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

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

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

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-2  
 I I TO 6/30/2008 I

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 8/ 1/2002

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 N

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

	1	2	3	4
28.01	100	0.8320	0.8335	
28.02	855.00	2	14	99914

28.02 ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY

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

	%	Y/N
28.03 STAFFING	0.10%	Y
28.04 RECRUITMENT	0.00%	
28.05 RETENTION	0.00%	
28.06 TRAINING	0.00%	
28.07	0.00%	
28.08	0.00%	
28.09	0.00%	
28.10	0.00%	
28.11	0.00%	
28.12	0.00%	
28.13	0.00%	
28.14	0.00%	
28.15	0.00%	
28.16	0.00%	
28.17	0.00%	
28.18	0.00%	
28.19	0.00%	
28.20	0.00%	

29 IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT? N

30 DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff) Y

30.01 IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70 N

30.02 IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS) N

30.03 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000). N

30.04 IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II N

31 IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.01 IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.02 IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.03 IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.04 IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

31.05 IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c). N

MISCELLANEOUS COST REPORT INFORMATION

32 IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2. N

33 IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2 N

34 IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA? N

35 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.01 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.02 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.03 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

35.04 HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)? N

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)

V	XVIII	XIX
1	2	3
N	N	N

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

I PROVIDER NO: 14-1321  
 I PERIOD: FROM 7/1/2007 TO 6/30/2008  
 I PREPARED 11/21/2008  
 I WORKSHEET S-2

- 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

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

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

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

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

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

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

54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N

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

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

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

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

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

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

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

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

HOSPITAL & HOSPITAL HEALTH CARE COMPLEX  
IDENTIFICATION DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-2  
I I TO 6/30/2008 I

FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)

N

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

0

MULTICAMPUS

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE  
COMPLEX STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-3  
I TO 6/30/2008 I PART I

COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	TITLE V 3	I/P DAYS / TITLE XVIII 4	O/P VISITS / NOT LTCH N/A 4.01	TRIPS TOTAL TITLE XIX 5
1 ADULTS & PEDIATRICS	25	9,150	54,984.00			1,366	101
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF						70	
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS	25	9,150	54,984.00			1,436	101
12 TOTAL	25	9,150	54,984.00			1,436	101
13 RPCH VISITS							
15 SKILLED NURSING FACILITY	83	30,378				6,693	
24 RURAL HEALTH CLINIC						2,821	
25 TOTAL	108						
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	TITLE XIX OBSERVATION BEDS ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. TOTAL 7	FTES -- LESS I&R REPL NON-PHYS ANES 8
1 ADULTS & PEDIATRICS			1,566				
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF			70				
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS			1,636				
12 TOTAL			1,636				
13 RPCH VISITS							
15 SKILLED NURSING FACILITY			25,820				
24 RURAL HEALTH CLINIC			10,270				
25 TOTAL							
26 OBSERVATION BED DAYS			320		320		
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	DISCHARGES TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1 ADULTS & PEDIATRICS					420	48	560
2 HMO							
2 01 HMO - (IRF PPS SUBPROVIDER)							
3 ADULTS & PED-SB SNF							
4 ADULTS & PED-SB NF							
5 TOTAL ADULTS AND PEDS							
12 TOTAL		134.13			420	48	560
13 RPCH VISITS							
15 SKILLED NURSING FACILITY		1.00					
24 RURAL HEALTH CLINIC		11.94					
25 TOTAL		147.07					
26 OBSERVATION BED DAYS							
27 AMBULANCE TRIPS							
28 EMPLOYEE DISCOUNT DAYS							
28 01 EMP DISCOUNT DAYS -IRF							

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	10/1 DAYS 3.01	SERVICES ON/AFTER 10/1 RATE	10/1 DAYS 4.01	SRVCS 4/1/01 TO 9/30/01 RATE	4.02	DAYS 4.03
1	RUC		402					
2	RUB		890					
3	RUA		424					
3 .01	RUX		217					
3 .02	RUL		100					
4	RVC		581					
5	RVB		780					
6	RVA		706					
6 .01	RVX		80					
6 .02	RVL		218					
7	RHC		352					
8	RHB		265					
9	RHA		125					
9 .01	RHX							
9 .02	RHL							
10	RMC		50					
11	RMB		84					
12	RMA		16					
12 .01	RMX		248					
12 .02	RML		287					
13	RLB							
14	RLA		10					
14 .01	RLX							
15	SE3							
16	SE2		206					
17	SE1		27					
18	SSC		1					
19	SSB		60					
20	SSA		159					
21	CC2		30					
22	CC1		155					
23	CB2							
24	CB1		91					
25	CA2							
26	CA1		59					
27	IB2							
28	IB1							
29	IA2							
30	IA1							
31	BB2							
32	BB1							
33	BA2							
34	BA1							
35	PE2							
36	PE1		12					
37	PD2							
38	PD1		28					
39	PC2		30					
40	PC1							
41	PB2							
42	PB1							
43	PA2							
44	PA1							
45	Default							
46	TOTAL		6,693					

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

Worksheet S-2 reference data:  
 Transition Period : 100% Federal  
 Wage Index Factor (before 10/01): 0.8320  
 Wage Index Factor (after 10/01) : 0.8335  
 SNF Facility Specific Rate : 855.00  
 Urban/Rural Designation : RURAL  
 SNF MSA Code : 14  
 SNF CBSA Code : 99914

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-7  
 I I TO 6/30/2008 I

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

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

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

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

Worksheet S-2 reference data:  
 Transition Period : 100% Federal  
 Wage Index Factor (before 10/01): 0.8320  
 Wage Index Factor (after 10/01) : 0.8335  
 SNF Facility Specific Rate : 855.00  
 Urban/Rural Designation : RURAL  
 SNF MSA Code : 14  
 SNF CBSA Code : 99914

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-7  
I TO 6/30/2008 I NOT A CMS WORKSHEET  
SERVICES THROUGH 12/31/2005

	GROUP(1)	M3PI REVENUE CODE	SERVICES	PRIOR TO	OCTOBER 1ST	SERVICES	ON OR AFTER	OCTOBER 1ST
			BASE RATE	RATE	DAYS	BASE RATE	RATE	DAYS
	1		3a	3	3.01	4a	4	4.01
1	RUC		458.21			478.65	478.65	402
2	RUB		423.86			442.78	442.78	890
3	RUA		406.10			424.23	424.23	424
3 .01	RUX		531.62			555.34	555.34	217
3 .02	RUL		472.41			493.49	493.49	100
4	RVC		361.85			378.00	378.00	581
5	RVB		345.27			360.68	360.68	780
6	RVA		313.30			327.29	327.29	706
6 .01	RVX		398.56			416.34	416.34	80
6 .02	RVL		373.70			390.37	390.37	218
7	RHC		310.08			323.91	323.91	352
8	RHB		297.06			310.31	310.31	265
9	RHA		276.93			289.28	289.28	125
9 .01	RHX		333.76			348.65		
9 .02	RHL		327.84			342.47		
10	RMC		283.49			296.13	296.13	50
11	RMB		276.38			288.72	288.72	84
12	RMA		270.46			282.53	282.53	16
12 .01	RMX		375.84			392.62	392.62	248
12 .02	RML		346.24			361.69	361.69	287
13	RLB		245.70			256.66		
14	RLA		211.37			220.79	220.79	10
14 .01	RLX		265.84			277.69		
15	SE3		297.80			311.09		
16	SE2		253.99			265.33	265.33	206
17	SE1		226.75			236.87	236.87	27
18	SSC		223.20			233.17	233.17	1
19	SSB		211.36			220.79	220.79	60
20	SSA		207.81			217.09	217.09	159
21	CC2		222.01			231.93	231.93	30
22	CC1		203.07			212.13	212.13	155
23	CB2		193.60			202.24		
24	CB1		185.31			193.58	193.58	91
25	CA2		184.12			192.34		
26	CA1		172.28			179.97	179.97	59
27	IB2		165.18			172.55		
28	IB1		162.81			170.08		
29	IA2		149.79			156.47		
30	IA1		143.86			150.28		
31	BB2		163.99			171.32		
32	BB1		159.26			166.37		
33	BA2		148.60			155.24		
34	BA1		139.13			145.34		
35	PE2		178.21			186.16		
36	PE1		174.65			182.45	182.45	12
37	PD2		169.92			177.50		
38	PD1		167.55			175.03	175.03	28
39	PC2		161.63			168.85	168.85	30
40	PC1		159.26			166.37		
41	PB2		142.69			149.05		
42	PB1		141.50			147.81		
43	PA2		140.31			146.57		
44	PA1		136.76			142.87		
45	Default		136.76			142.87		
46	TOTAL							6,693

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

Worksheet S-2 reference data:  
 Transition Period : 100% Federal  
 Wage Index Factor (before 10/01): 0.8320  
 Wage Index Factor (after 10/01) : 0.8335  
 SNF Facility Specific Rate : 855.00  
 Urban/Rural Designation : RURAL  
 SNF MSA Code : 14  
 SNF CBSA Code : 99914

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

PROSPECTIVE PAYMENT FOR SNF  
STATISTICAL DATA

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-7  
I I TO 6/30/2008 I NOT A CMS WORKSHEET  
SERVICES THROUGH 12/31/2005

GROUP(1)	M3PI REVENUE CODE	A I D S		DIAGNOSIS		CODE 042		SWING		TOTAL
		SERV PRIOR	TO OCT. 1ST	SERV ON/AFTER	OCT. 1ST	BED SNF	DAYS	DAYS		
1	2	RATE	DAYS	RATE	DAYS	DAYS	DAYS	DAYS		
		4.02	4.03	4.04	4.05			4.06	5	
1	RUC	1,044.72		1,091.32					192,417	
2	RUB	966.40		1,009.54					394,074	
3	RUA	925.91		967.24					179,874	
3 .01	RUX	1,212.09		1,266.18					120,509	
3 .02	RUL	1,077.09		1,125.16					49,349	
4	RVC	825.02		861.84					219,618	
5	RVB	787.22		822.35					281,330	
6	RVA	714.32		746.22					231,067	
6 .01	RVX	908.72		949.26					33,307	
6 .02	RVL	852.04		890.04					85,101	
7	RHC	706.98		738.51					114,016	
8	RHB	677.30		707.51					82,232	
9	RHA	631.40		659.56					36,160	
9 .01	RHX	760.97		794.92						
9 .02	RHL	747.48		780.83						
10	RMC	646.36		675.18					14,807	
11	RMB	630.15		658.28					24,252	
12	RMA	616.65		644.17					4,520	
12 .01	RMX	856.92		895.17					97,370	
12 .02	RML	789.43		824.65					103,805	
13	RLB	560.20		585.18						
14	RLA	481.92		503.40					2,208	
14 .01	RLX	606.12		633.13						
15	SE3	678.98		709.29						
16	SE2	579.10		604.95					54,658	
17	SE1	516.99		540.06					6,395	
18	SSC	508.90		531.63					233	
19	SSB	481.90		503.40					13,247	
20	SSA	473.81		494.97					34,517	
21	CC2	506.18		528.80					6,958	
22	CC1	463.00		483.66					32,880	
23	CB2	441.41		461.11						
24	CB1	422.51		441.36					17,616	
25	CA2	419.79		438.54						
26	CA1	392.80		410.33					10,618	
27	IB2	376.61		393.41						
28	IB1	371.21		387.78						
29	IA2	341.52		356.75						
30	IA1	328.00		342.64						
31	BB2	373.90		390.61						
32	BB1	363.11		379.32						
33	BA2	338.81		353.95						
34	BA1	317.22		331.38						
35	PE2	406.32		424.44						
36	PE1	398.20		415.99					2,189	
37	PD2	387.42		404.70						
38	PD1	382.01		399.07					4,901	
39	PC2	368.52		384.98					5,066	
40	PC1	363.11		379.32						
41	PB2	325.33		339.83						
42	PB1	322.62		337.01						
43	PA2	319.91		334.18						
44	PA1	311.81		325.74						
45	Default	311.81		325.74						
46	TOTAL								2,455,294	

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

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

Worksheet S-2 reference data:  
 Transition Period : 100% Federal  
 Wage Index Factor (before 10/01): 0.8320  
 Wage Index Factor (after 10/01): 0.8335  
 SNF Facility Specific Rate : 855.00  
 Urban/Rural Designation : RURAL  
 SNF MSA Code : 14  
 SNF CBSA Code : 99914

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

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

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET S-8  
I COMPONENT NO: I TO 6/30/2008 I  
I 14-3469 I

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 201 BAILEY LANE  
1.01 CITY: BENTON STATE: IL ZIP CODE: 62812 COUNTY: FRANKLIN  
2 DESIGNATION (FOR FQHC 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 DR	RESABA	
	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
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC	0		900	2200	900	2200	900	2200	900	2200	900	2200	900	2200

(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.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO:  
I 14-1321  
I

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

I PREPARED 11/21/2008  
I WORKSHEET A  
I

COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
	GENERAL SERVICE COST CNTR					
3	0300 NEW CAP REL COSTS-BLDG & FIXT		455,370	455,370		455,370
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		275,106	275,106	20,449	295,555
5	0500 EMPLOYEE BENEFITS	46,085	1,243,350	1,289,435		1,289,435
6	0600 ADMINISTRATIVE & GENERAL	914,352	1,130,564	2,044,916	292,313	2,337,229
7	0700 MAINTENANCE & REPAIRS	203,456	222,036	425,492		425,492
8	0800 OPERATION OF PLANT		474,850	474,850		474,850
9	0900 LAUNDRY & LINEN SERVICE		25,009	25,009		25,009
10	1000 HOUSEKEEPING	160,891	45,459	206,350		206,350
11	1100 DIETARY	354,220	337,813	692,033	-131,487	560,546
12	1200 CAFETERIA				131,487	131,487
14	1400 NURSING ADMINISTRATION	373,718	8,833	382,551		382,551
17	1700 MEDICAL RECORDS & LIBRARY	149,886	62,129	212,015		212,015
18	1800 SOCIAL SERVICE					
	INPAT ROUTINE SRVC CNTRS					
25	2500 ADULTS & PEDIATRICS	856,021	44,455	900,476	-26,557	873,919
34	3400 SKILLED NURSING FACILITY	1,700,934	1,878,907	3,579,841		3,579,841
	ANCILLARY SRVC COST CNTRS					
37	3700 OPERATING ROOM	185,561	55,902	241,463	20,338	261,801
40	4000 ANESTHESIOLOGY		96,092	96,092	-4,407	91,685
41	4100 RADIOLOGY-DIAGNOSTIC	424,017	203,972	627,989	-62,683	565,306
44	4400 LABORATORY	325,260	495,204	820,464	-304,033	516,431
49	4900 RESPIRATORY THERAPY	224,170	102,426	326,596	-22,709	303,887
50	5000 PHYSICAL THERAPY	22,474	151,688	174,162	-2,879	171,283
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS	66,774	128,262	195,036	447,727	642,763
56	5600 DRUGS CHARGED TO PATIENTS	137,450	369,804	507,254	-1,362	505,892
59	3020 SNF PT					
	OUTPAT SERVICE COST CNTRS					
60	6000 CLINIC	155,129	168,045	323,174		323,174
61	6100 EMERGENCY	620,734	1,184,307	1,805,041	-31,570	1,773,471
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950 OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310 RURAL HEALTH CLINIC	675,782	75,661	751,443	-11,732	739,711
	SPEC PURPOSE COST CENTERS					
88	8800 INTEREST EXPENSE		312,762	312,762	-312,762	
95	SUBTOTALS	7,596,914	9,548,006	17,144,920	133	17,145,053
	NONREIMBURS COST CENTERS					
100.01	7951 UNASSIGNED SPACE					
100.02	7952 LEASED CLINICS	149,841		149,841	-133	149,708
100.03	7953 MARKETING	52,846	85,883	138,729		138,729
101	TOTAL	7,799,601	9,633,889	17,433,490	-0-	17,433,490

RECLASSIFICATION AND ADJUSTMENT OF  
TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET A  
I I TO 6/30/2008 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		455,370
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		295,555
5	0500 EMPLOYEE BENEFITS		1,289,435
6	0600 ADMINISTRATIVE & GENERAL	-27,105	2,310,124
7	0700 MAINTENANCE & REPAIRS		425,492
8	0800 OPERATION OF PLANT	-195,519	279,331
9	0900 LAUNDRY & LINEN SERVICE		25,009
10	1000 HOUSEKEEPING		206,350
11	1100 DIETARY	-238,911	321,635
12	1200 CAFETERIA	-88,197	43,290
14	1400 NURSING ADMINISTRATION		382,551
17	1700 MEDICAL RECORDS & LIBRARY		212,015
18	1800 SOCIAL SERVICE		
	INPAT ROUTINE SRVC CNTRS		
25	2500 ADULTS & PEDIATRICS		873,919
34	3400 SKILLED NURSING FACILITY		3,579,841
	ANCILLARY SRVC COST CNTRS		
37	3700 OPERATING ROOM	-12,000	249,801
40	4000 ANESTHESIOLOGY	-87,628	4,057
41	4100 RADIOLOGY-DIAGNOSTIC		565,306
44	4400 LABORATORY	-35,607	480,824
49	4900 RESPIRATORY THERAPY	-36,000	267,887
50	5000 PHYSICAL THERAPY		171,283
55	5500 MEDICAL SUPPLIES CHARGED TO PATIENTS		642,763
56	5600 DRUGS CHARGED TO PATIENTS	-7,203	498,689
59	3020 SNF PT		
	OUTPAT SERVICE COST CNTRS		
60	6000 CLINIC		323,174
61	6100 EMERGENCY	-823,677	949,794
62	6200 OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950 OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310 RURAL HEALTH CLINIC		739,711
	SPEC PURPOSE COST CENTERS		
88	8800 INTEREST EXPENSE		-0-
95	SUBTOTALS	-1,551,847	15,593,206
	NONREIMBURS COST CENTERS		
100.01	7951 UNASSIGNED SPACE		
100.02	7952 LEASED CLINICS		149,708
100.03	7953 MARKETING		138,729
101	TOTAL	-1,551,847	15,881,643

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET  
 I I TO 6/30/2008 I

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	SNF PT	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 #####
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
95	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
100.01	UNASSIGNED SPACE	7951	OTHER NONREIMBURSABLE COST CENTERS
100.02	LEASED CLINICS	7952	OTHER NONREIMBURSABLE COST CENTERS
100.03	MARKETING	7953	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

RECLASSIFICATIONS

PROVIDER NO:	PERIOD:	PREPARED
141321	FROM 7/ 1/2007	11/21/2008
	TO 6/30/2008	

EXPLANATION OF RECLASSIFICATION	CODE		INCREASE		
	(1)	COST CENTER	LINE NO	SALARY	OTHER
	1	2	3	4	5
1 CAFETERIA	A	CAFETERIA	12	67,302	64,185
2 MED SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		447,727
3		OPERATING ROOM	37		20,338
4					
5					
6					
7					
8					
9					
10					
11					
12					
13 INTEREST	C	NEW CAP REL COSTS-MVBLE EQUIP	4		20,449
14		ADMINISTRATIVE & GENERAL	6		292,313
36 TOTAL RECLASSIFICATIONS				67,302	845,012

(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
141321	FROM 7/ 1/2007	11/21/2008
	TO 6/30/2008	WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION	CODE (1)	COST CENTER	DECREASE			A-7 REF 10
			LINE NO	SALARY	OTHER	
1 CAFETERIA	A	DIETARY	11	67,302	64,185	
2 MED SUPPLIES	B	ADULTS & PEDIATRICS	25		26,557	
3						
4		ANESTHESIOLOGY	40		4,407	
5		RADIOLOGY-DIAGNOSTIC	41		62,683	
6		LABORATORY	44		304,033	
7		RESPIRATORY THERAPY	49		22,709	
8		PHYSICAL THERAPY	50		2,879	
9		DRUGS CHARGED TO PATIENTS	56		1,362	
10		EMERGENCY	61		31,570	
11		RURAL HEALTH CLINIC	63.50		11,732	
12		LEASED CLINICS	100.02		133	
13 INTEREST	C	INTEREST EXPENSE	88		312,762	11
14						
36 TOTAL RECLASSIFICATIONS				67,302	845,012	

(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
141321	FROM 7/ 1/2007	11/21/2008
	TO 6/30/2008	WORKSHEET A-6
		NOT A CMS WORKSHEET

RECLASS CODE: A  
EXPLANATION : CAFETERIA

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	CAFETERIA	12	131,487	DIETARY	11	131,487	
TOTAL RECLASSIFICATIONS FOR CODE A			131,487				131,487

RECLASS CODE: B  
EXPLANATION : MED SUPPLIES

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	447,727	ADULTS & PEDIATRICS	25	26,557	
2.00	OPERATING ROOM	37	20,338			0	
3.00			0	ANESTHESIOLOGY	40	4,407	
4.00			0	RADIOLOGY-DIAGNOSTIC	41	62,683	
5.00			0	LABORATORY	44	304,033	
6.00			0	RESPIRATORY THERAPY	49	22,709	
7.00			0	PHYSICAL THERAPY	50	2,879	
8.00			0	DRUGS CHARGED TO PATIENTS	56	1,362	
9.00			0	EMERGENCY	61	31,570	
10.00			0	RURAL HEALTH CLINIC	63.50	11,732	
11.00			0	LEASED CLINICS	100.02	133	
TOTAL RECLASSIFICATIONS FOR CODE B			468,065				468,065

RECLASS CODE: C  
EXPLANATION : INTEREST

----- INCREASE -----				----- DECREASE -----			
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT	
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	20,449	INTEREST EXPENSE	88	312,762	
2.00	ADMINISTRATIVE & GENERAL	6	292,313			0	
TOTAL RECLASSIFICATIONS FOR CODE C			312,762				312,762

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	COMPUTATION OF RATIOS			RATIO	ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO		INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV								
5	TOTAL				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	455,370						455,370
4	NEW CAP REL COSTS-MV	275,106		20,449				295,555
5	TOTAL	730,476		20,449				750,925

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	455,370						455,370
4	NEW CAP REL COSTS-MV	275,106						275,106
5	TOTAL	730,476						730,476

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

ADJUSTMENTS TO EXPENSES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET A-8  
 I I TO 6/30/2008 I

DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		LINE NO 4	WKST. A-7 REF. 5
			COST CENTER 3			
1 INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		1	
2 INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**		2	
3 INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &		3	
4 INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E		4	11
5 INVESTMENT INCOME-OTHER	B	-12,907	ADMINISTRATIVE & GENERAL		6	
6 TRADE, QUANTITY AND TIME DISCOUNTS	B	-361	ADMINISTRATIVE & GENERAL		6	
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	-993,087				
13 SALE OF SCRAP, WASTE, ETC.						
14 RELATED ORGANIZATION TRANSACTIONS	A-8-1					
15 LAUNDRY AND LINEN SERVICE						
16 CAFETERIA--EMPLOYEES AND GUESTS	B	-88,197	CAFETERIA		12	
17 RENTAL OF QTRS TO EMPLOYEE AND OTHRS	B	-78,000	OPERATION OF PLANT		8	
18 SALE OF MED AND SURG SUPPLIES						
19 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-7,203	DRUGS CHARGED TO PATIENTS		56	
20 SALE OF MEDICAL RECORDS & ABSTRACTS						
21 NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)						
22 VENDING MACHINES						
23 INCOME FROM IMPOSITION OF INTEREST						
24 INTRST EXP ON MEDICARE OVERPAYMENTS						
25 ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY		49	
26 ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY		50	
27 ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3					
28 UTILIZATION REVIEW-PHYSIAN COMP						
29 DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**		89	
30 DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**		1	
31 DEPRECIATION-NEW BLDGS AND FIXTURES			**COST CENTER DELETED**		2	
32 DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-BLDG &		3	
33 NON-PHYSICIAN ANESTHETIST			NEW CAP REL COSTS-MVBLE E		4	
34 PHYSICIANS' ASSISTANT			**COST CENTER DELETED**		20	
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 DIETARY	B	-538	DIETARY		11	
38 MISCELLANEOUS INCOME	B	-9,062	ADMINISTRATIVE & GENERAL		6	
39 ADVERTISING	B	-2,704	ADMINISTRATIVE & GENERAL		6	
40 LAB REVENUE	B	-1,825	LABORATORY		44	
41 NON CAH MISCELLANEOUS INCOME	B	-2,071	ADMINISTRATIVE & GENERAL		6	
42 BENTON DIETARY	B	-238,373	DIETARY		11	
43 BENTON UTILITIES	B	-117,519	OPERATION OF PLANT		8	
44						
45 OTHER ADJUSTMENTS (SPECIFY)						
46 OTHER ADJUSTMENTS (SPECIFY)						
47 OTHER ADJUSTMENTS (SPECIFY)						
48 OTHER ADJUSTMENTS (SPECIFY)						
49 OTHER ADJUSTMENTS (SPECIFY)						
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,551,847				

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

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET A-8-2  
 I I TO 6/30/2008 I GROUP 1

LINE NO.	WKSHT A 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	37	OR	12,000	12,000					
2	40	ANESTHESIA	87,628	87,628					
3	44	LAB	33,782	33,782					
4	49	RT	36,000	36,000					
5	61	ER	1,113,077	823,677	289,400				
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,282,487	993,087	289,400				



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

IN LIEU OF FORM CMS-2552-96(12/1999)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET A-8-4  
 I I TO 6/30/2008 I PARTS I - VII

PHYSICAL THERAPY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	163
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	61
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED				
10	AHSEA (SEE INSTRUCTIONS)		683.00		2543.00
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE-HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	28.93	57.85 28.93	57.85	28.93
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	39,512
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	147,113
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS )	186,625
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	186,625

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

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	186,625

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

STANDARD TRAVEL ALLOWANCE	
24	THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	
29	THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)

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

I PROVIDER NO: I 14-1321  
 I PERIOD: I FROM 7/ 1/2007 I TO 6/30/2008  
 I PREPARED 11/21/2008 I WORKSHEET A-8-4 I PARTS I - VII

PHYSICAL THERAPY

32 OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)  
 33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 7,254  
 34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)  
 35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

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

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 186,625  
 58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 7,254  
 59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)  
 60 OVERTIME ALLOWANCE (FROM COLUMN 5, LINE 56)  
 61 EQUIPMENT COST (SEE INSTRUCTIONS)  
 62 SUPPLIES (SEE INSTRUCTIONS)

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

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET A-8-4  
 I I TO 6/30/2008 I PARTS I - VII

PHYSICAL THERAPY

63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 193,879  
 64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 145,252  
 65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

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

66 COST OF OUTSIDE SUPPLIER SERVICES - 145,252  
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)  
 66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I  
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)  
 66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I  
 (SEE INSTRUCTIONS)(FROM YOUR RECORDS)  
 67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS LINE MUST AGREE WITH LINE 64) 145,252  
 68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000  
 68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)  
 68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)  
 69 EXCESS COST OVER LIMITATION- (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)  
 69.01 EXCESS COST OVER LIMITATION-CORF I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)  
 69.31 EXCESS COST OVER LIMITATION- HHA I (SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES AS INDICATED IN INSTRUCTIONS)  
 70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE 69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE WITH LINE 65)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I NOT A CMS WORKSHEET  
 I I TO 6/30/2008 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	2	SQ FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF SERVICE	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	FTES	ENTERED
14	NURSING ADMINISTRATION	13	NRSNG FTES	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	GROSS REV	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
	0	3	4	5	5a.00	6	7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &	455,370	455,370					
005 NEW CAP REL COSTS-MVBLE E	295,555		295,555				
006 EMPLOYEE BENEFITS	1,289,435	1,313		1,290,748			
007 ADMINISTRATIVE & GENERAL	2,310,124	47,350	43,413	188,581	2,589,468	2,589,468	
008 MAINTENANCE & REPAIRS	425,492	18,937	8,921	41,962	495,312	132,058	627,370
009 OPERATION OF PLANT	279,331	59,747	816		339,894	90,621	123,670
010 LAUNDRY & LINEN SERVICE	25,009	5,204	147		30,360	8,094	10,771
011 HOUSEKEEPING	206,350	1,750	421	33,183	241,704	64,442	3,623
012 DIETARY	321,635	34,413	10,820	56,389	423,257	112,847	71,230
014 CAFETERIA	43,290			16,668	59,958	15,986	
017 NURSING ADMINISTRATION	382,551	2,610	257	77,078	462,496	123,309	5,402
018 MEDICAL RECORDS & LIBRARY	212,015	7,296	4,492	30,913	254,716	67,911	15,102
025 SOCIAL SERVICE		2,761			2,761	736	5,715
034 INPAT ROUTINE SRVC CNTRS							
034 ADULTS & PEDIATRICS	873,919	41,669	10,345	176,551	1,102,484	293,944	86,250
037 SKILLED NURSING FACILITY	3,579,841				3,579,841		
040 ANCILLARY SRVC COST CNTRS							
040 OPERATING ROOM	249,801	44,685	22,565	38,271	355,322	94,735	92,492
041 ANESTHESIOLOGY	4,057	716	225		4,998	1,333	1,482
041 RADIOLOGY-DIAGNOSTIC	565,306	19,160	147,459	87,452	819,377	218,459	39,658
044 LABORATORY	480,824	10,296	25,809	67,084	584,013	155,707	21,311
049 RESPIRATORY THERAPY	267,887	12,070	3,429	46,234	329,620	87,882	24,984
050 PHYSICAL THERAPY	171,283	10,726	740	4,635	187,384	49,960	22,201
055 MEDICAL SUPPLIES CHARGED	642,763	17,568	858	13,772	674,961	179,955	36,365
056 DRUGS CHARGED TO PATIENTS	498,689	7,400		28,349	534,438	142,490	15,317
059 SNF PT							
060 OUTPAT SERVICE COST CNTRS							
061 CLINIC	323,174	9,063		31,995	364,232	97,110	18,759
062 EMERGENCY	949,794	15,961	5,314	128,024	1,099,093	293,036	33,038
063 OBSERVATION BEDS (NON-DIS							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC	739,711	29,416	9,524	139,377	918,028	244,761	
095 SPEC PURPOSE COST CENTERS							
095 SUBTOTALS	15,593,206	400,111	295,555	1,206,518	15,453,717	2,475,376	627,370
100 NONREIMBURS COST CENTERS							
100 01 UNASSIGNED SPACE		859			859	229	
100 02 LEASED CLINICS	149,708	54,400		73,331	277,439	73,970	
100 03 MARKETING	138,729			10,899	149,628	39,893	
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	15,881,643	455,370	295,555	1,290,748	15,881,643	2,589,468	627,370

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	554,185						
010 LAUNDRY & LINEN SERVICE	10,573	59,798					
011 HOUSEKEEPING	3,557		313,326				
012 DIETARY	69,918			677,252			
014 CAFETERIA			11,942		87,886		
017 NURSING ADMINISTRATION	5,302				3,426	599,935	
018 MEDICAL RECORDS & LIBRARY	14,824		13,648		4,516		370,717
025 SOCIAL SERVICE	5,610						
034 INPAT ROUTINE SRVC CNTRS							
037 ADULTS & PEDIATRICS	84,661	24,515	71,649	677,252	17,369	224,469	26,872
040 SKILLED NURSING FACILITY							
041 ANCILLARY SRVC COST CNTRS							
044 OPERATING ROOM	90,786	7,398	51,178		3,740	48,345	17,031
049 ANESTHESIOLOGY	1,455						2,876
050 RADIOLOGY-DIAGNOSTIC	38,928	11,213	15,354		9,817		91,941
055 LABORATORY	20,919		17,628		9,513		80,216
056 RESPIRATORY THERAPY	24,524		25,589		4,879		32,079
059 PHYSICAL THERAPY	21,792	2,947	10,236		10		4,085
060 MEDICAL SUPPLIES CHARGED	35,694				1,983		8,047
061 DRUGS CHARGED TO PATIENTS	15,034		3,412		2,513		31,442
062 SNF PT							
063 OUTPAT SERVICE COST CNTRS							
066 CLINIC	18,413	439			3,829		16,368
069 EMERGENCY	32,429	13,286	39,237		13,587	175,615	59,760
072 OBSERVATION BEDS (NON-DIS							
075 OTHER OUTPATIENT SERVICE							
080 RURAL HEALTH CLINIC	59,766		53,453		11,722	151,506	
085 SPEC PURPOSE COST CENTERS							
090 SUBTOTALS	554,185	59,798	313,326	677,252	86,904	599,935	370,717
095 NONREIMBURS COST CENTERS							
100 01 UNASSIGNED SPACE							
100 02 LEASED CLINICS							
100 03 MARKETING					982		
101 CROSS FOOT ADJUSTMENT							
102 NEGATIVE COST CENTER							
103 TOTAL	554,185	59,798	313,326	677,252	87,886	599,935	370,717

COST ALLOCATION - GENERAL SERVICE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART I

COST CENTER DESCRIPTION	SOCIAL SERVIC E	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
	18	25	26	27
003 GENERAL SERVICE COST CNTR				
004 NEW CAP REL COSTS-BLDG &				
005 NEW CAP REL COSTS-MVBLE E				
006 EMPLOYEE BENEFITS				
007 ADMINISTRATIVE & GENERAL				
008 MAINTENANCE & REPAIRS				
009 OPERATION OF PLANT				
010 LAUNDRY & LINEN SERVICE				
011 HOUSEKEEPING				
012 DIETARY				
014 CAFETERIA				
017 NURSING ADMINISTRATION				
018 MEDICAL RECORDS & LIBRARY				
SOCIAL SERVICE	14,822			
025 INPAT ROUTINE SRVC CNTRS				
ADULTS & PEDIATRICS	14,822	2,624,287		2,624,287
034 SKILLED NURSING FACILITY				
ANCILLARY SRVC COST CNTRS		3,579,841		3,579,841
037 OPERATING ROOM		761,027		761,027
040 ANESTHESIOLOGY		12,144		12,144
041 RADIOLOGY-DIAGNOSTIC		1,244,747		1,244,747
044 LABORATORY		889,307		889,307
049 RESPIRATORY THERAPY		529,557		529,557
050 PHYSICAL THERAPY		298,615		298,615
055 MEDICAL SUPPLIES CHARGED		937,005		937,005
056 DRUGS CHARGED TO PATIENTS		744,646		744,646
059 SNF PT				
060 OUTPAT SERVICE COST CNTRS				
CLINIC		519,150		519,150
061 EMERGENCY		1,759,081		1,759,081
062 OBSERVATION BEDS (NON-DIS				
063 OTHER OUTPATIENT SERVICE				
063 50 RURAL HEALTH CLINIC		1,439,236		1,439,236
SPEC PURPOSE COST CENTERS				
095 SUBTOTALS	14,822	15,338,643		15,338,643
NONREIMBURS COST CENTERS				
100 01 UNASSIGNED SPACE		1,088		1,088
100 02 LEASED CLINICS		351,409		351,409
100 03 MARKETING		190,503		190,503
101 CROSS FOOT ADJUSTMENT				
102 NEGATIVE COST CENTER				
103 TOTAL	14,822	15,881,643		15,881,643

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

COST CENTER DESCRIPTION	DIR ASSGND NEW CAPITAL REL COSTS 0	NEW CAP REL COSTS-BLDG & OSTS 3	NEW CAP REL COSTS-MVBLE E OSTS 4	SUBTOTAL 4a	EMPLOYEE BENEFITS 5	ADMINISTRATIVE & GENERAL E 6	MAINTENANCE & REPAIRS 7
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG & OSTS							
005 EMPLOYEE BENEFITS		1,313		1,313	1,313		
006 ADMINISTRATIVE & GENERAL		47,350	43,413	90,763	191	90,954	
007 MAINTENANCE & REPAIRS		18,937	8,921	27,858	43	4,639	32,540
008 OPERATION OF PLANT		59,747	816	60,563		3,183	6,415
009 LAUNDRY & LINEN SERVICE		5,204	147	5,351		284	559
010 HOUSEKEEPING		1,750	421	2,171	34	2,264	188
011 DIETARY		34,413	10,820	45,233	57	3,964	3,695
012 CAFETERIA					17	562	
014 NURSING ADMINISTRATION		2,610	257	2,867	78	4,331	280
017 MEDICAL RECORDS & LIBRARY		7,296	4,492	11,788	31	2,385	783
018 SOCIAL SERVICE		2,761		2,761		26	296
025 INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		41,669	10,345	52,014	180	10,323	4,474
034 SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS							
037 OPERATING ROOM		44,685	22,565	67,250	39	3,328	4,797
040 ANESTHESIOLOGY		716	225	941		47	77
041 RADIOLOGY-DIAGNOSTIC		19,160	147,459	166,619	89	7,673	2,057
044 LABORATORY		10,296	25,809	36,105	68	5,469	1,105
049 RESPIRATORY THERAPY		12,070	3,429	15,499	47	3,087	1,296
050 PHYSICAL THERAPY		10,726	740	11,466	5	1,755	1,151
055 MEDICAL SUPPLIES CHARGED		17,568	858	18,426	14	6,321	1,886
056 DRUGS CHARGED TO PATIENTS		7,400		7,400	29	5,005	794
059 SNF PT							
060 OUTPAT SERVICE COST CNTRS CLINIC		9,063		9,063	33	3,411	973
061 EMERGENCY		15,961	5,314	21,275	130	10,293	1,714
062 OBSERVATION BEDS (NON-DIS)							
063 OTHER OUTPATIENT SERVICE							
063 50 RURAL HEALTH CLINIC		29,416	9,524	38,940	142	8,597	
095 SPEC PURPOSE COST CENTERS SUBTOTALS		400,111	295,555	695,666	1,227	86,947	32,540
100 01 UNASSIGNED SPACE		859		859		8	
100 02 LEASED CLINICS		54,400		54,400	75	2,598	
100 03 MARKETING					11	1,401	
101 CROSS FOOT ADJUSTMENTS							
102 NEGATIVE COST CENTER							
103 TOTAL		455,370	295,555	750,925	1,313	90,954	32,540

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
	8	9	10	11	12	14	17
003 GENERAL SERVICE COST CNTR							
004 NEW CAP REL COSTS-BLDG &							
005 NEW CAP REL COSTS-MVBLE E							
006 EMPLOYEE BENEFITS							
007 ADMINISTRATIVE & GENERAL							
008 MAINTENANCE & REPAIRS							
009 OPERATION OF PLANT	70,161						
010 LAUNDRY & LINEN SERVICE	1,339	7,533					
011 HOUSEKEEPING	450		5,107				
012 DIETARY	8,852			61,801			
014 CAFETERIA			195		774		
017 NURSING ADMINISTRATION	671				30	8,257	
018 MEDICAL RECORDS & LIBRARY	1,877		222		40		17,126
025 SOCIAL SERVICE	710						
034 INPAT ROUTINE SRVC CNTRS	10,718	3,088	1,168	61,801	153	3,090	1,242
037 SKILLED NURSING FACILITY							
040 ANCILLARY SRVC COST CNTRS							
041 OPERATING ROOM	11,495	932	834		33	665	787
044 ANESTHESIOLOGY	184						133
049 RADIOLOGY-DIAGNOSTIC	4,928	1,413	250		86		4,240
050 LABORATORY	2,648		287		84		3,708
055 RESPIRATORY THERAPY	3,105		417		43		1,483
056 PHYSICAL THERAPY	2,759	371	167				189
059 MEDICAL SUPPLIES CHARGED	4,519				17		372
060 DRUGS CHARGED TO PATIENTS	1,903		56		22		1,453
061 SNF PT							
062 OUTPAT SERVICE COST CNTRS							
063 CLINIC	2,331	55			34		757
066 EMERGENCY	4,106	1,674	640		120	2,417	2,762
067 OBSERVATION BEDS (NON-DIS							
068 OTHER OUTPATIENT SERVICE							
069 RURAL HEALTH CLINIC	7,566		871		103	2,085	
070 SPEC PURPOSE COST CENTERS							
075 SUBTOTALS	70,161	7,533	5,107	61,801	765	8,257	17,126
100 01 NONREIMBURS COST CENTERS							
100 02 UNASSIGNED SPACE							
100 03 LEASED CLINICS							
101 03 MARKETING					9		
102 CROSS FOOT ADJUSTMENTS							
103 NEGATIVE COST CENTER							
103 TOTAL	70,161	7,533	5,107	61,801	774	8,257	17,126

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B  
 I I TO 6/30/2008 I PART III

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		18	25	26	27
003	GENERAL SERVICE COST CNTR				
004	NEW CAP REL COSTS-BLDG &				
005	NEW CAP REL COSTS-MVBLE E				
006	EMPLOYEE BENEFITS				
007	ADMINISTRATIVE & GENERAL				
008	MAINTENANCE & REPAIRS				
009	OPERATION OF PLANT				
010	LAUNDRY & LINEN SERVICE				
011	HOUSEKEEPING				
012	DIETARY				
014	CAFETERIA				
017	NURSING ADMINISTRATION				
018	MEDICAL RECORDS & LIBRARY				
018	SOCIAL SERVICE	3,793			
025	INPAT ROUTINE SRVC CNTRS				
034	ADULTS & PEDIATRICS	3,793	152,044		152,044
037	SKILLED NURSING FACILITY				
040	ANCILLARY SRVC COST CNTRS				
040	OPERATING ROOM		90,160		90,160
041	ANESTHESIOLOGY		1,382		1,382
041	RADIOLOGY-DIAGNOSTIC		187,355		187,355
044	LABORATORY		49,474		49,474
049	RESPIRATORY THERAPY		24,977		24,977
050	PHYSICAL THERAPY		17,863		17,863
055	MEDICAL SUPPLIES CHARGED		31,555		31,555
056	DRUGS CHARGED TO PATIENTS		16,662		16,662
059	SNF PT				
060	OUTPAT SERVICE COST CNTRS				
061	CLINIC		16,657		16,657
061	EMERGENCY		45,131		45,131
062	OBSERVATION BEDS (NON-DIS				
063	OTHER OUTPATIENT SERVICE				
063 50	RURAL HEALTH CLINIC		58,304		58,304
095	SPEC PURPOSE COST CENTERS				
095	SUBTOTALS	3,793	691,564		691,564
100 01	NONREIMBURS COST CENTERS				
100 01	UNASSIGNED SPACE		867		867
100 02	LEASED CLINICS		57,073		57,073
100 03	MARKETING		1,421		1,421
101	CROSS FOOT ADJUSTMENTS				
102	NEGATIVE COST CENTER				
103	TOTAL	3,793	750,925		750,925

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

COST CENTER DESCRIPTION	NEW CAP REL C	NEW CAP REL C	EMPLOYEE BENE	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	
	OSTS-BLDG & (SQUARE FEET	OSTS-MVBLE (DOLLAR )VALUE	E FITS (GROSS )ALARIES			S RECONCIL- ) IATION
	3	4	5	6a.00	6	7
003 GENERAL SERVICE COST						
004 NEW CAP REL COSTS-BLD	57,231					
005 NEW CAP REL COSTS-MVB		244,867				
006 EMPLOYEE BENEFITS	165		6,258,294			
007 ADMINISTRATIVE & GENE	5,951	35,968	914,352	-2,589,468	9,712,334	
008 MAINTENANCE & REPAIRS	2,380	7,391	203,456		495,312	38,093
009 OPERATION OF PLANT	7,509	676			339,894	7,509
010 LAUNDRY & LINEN SERVI	654	122			30,360	654
011 HOUSEKEEPING	220	349	160,891		241,704	220
012 DIETARY	4,325	8,964	273,405		423,257	4,325
014 CAFETERIA			80,815		59,958	
017 NURSING ADMINISTRATIO	328	213	373,718		462,496	328
018 MEDICAL RECORDS & LIB	917	3,722	149,886		254,716	917
025 SOCIAL SERVICE	347				2,761	347
034 INPAT ROUTINE SRVC CN						
ADULTS & PEDIATRICS	5,237	8,571	856,021		1,102,484	5,237
037 SKILLED NURSING FACIL				-3,579,841		
040 ANCELLARY SRVC COST C						
OPERATING ROOM	5,616	18,695	185,561		355,322	5,616
041 ANESTHESIOLOGY	90	186			4,998	90
044 RADIOLOGY-DIAGNOSTIC	2,408	122,168	424,017		819,377	2,408
049 LABORATORY	1,294	21,383	325,260		584,013	1,294
050 RESPIRATORY THERAPY	1,517	2,841	224,170		329,620	1,517
055 PHYSICAL THERAPY	1,348	613	22,474		187,384	1,348
056 MEDICAL SUPPLIES CHAR	2,208	711	66,774		674,961	2,208
059 DRUGS CHARGED TO PATI	930		137,450		534,438	930
060 SNF PT						
060 OUTPAT SERVICE COST C						
061 CLINIC	1,139		155,129		364,232	1,139
062 EMERGENCY	2,006	4,403	620,734		1,099,093	2,006
063 OBSERVATION BEDS (NON						
063 50 OTHER OUTPATIENT SERV						
RURAL HEALTH CLINIC	3,697	7,891	675,782		918,028	
095 SPEC PURPOSE COST CEN						
SUBTOTALS	50,286	244,867	5,849,895	-6,169,309	9,284,408	38,093
100 01 NONREIMBURS COST CENT						
UNASSIGNED SPACE	108				859	
100 02 LEASED CLINICS	6,837		355,553		277,439	
100 03 MARKETING			52,846		149,628	
101 CROSS FOOT ADJUSTMENT						
102 NEGATIVE COST CENTER						
103 COST TO BE ALLOCATED	455,370	295,555	1,290,748		2,589,468	627,370
(WRKSHT B, PART I)						
104 UNIT COST MULTIPLIER	7.956702		.206246		.266616	
(WRKSHT B, PT I)		1.207002				16.469430
105 COST TO BE ALLOCATED						
(WRKSHT B, PART II)						
106 UNIT COST MULTIPLIER						
(WRKSHT B, PT II)						
107 COST TO BE ALLOCATED			1,313		90,954	32,540
(WRKSHT B, PART III)						
108 UNIT COST MULTIPLIER			.000210		.009365	.854225
(WRKSHT B, PT III)						

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
		(SQ FEET)	(POUNDS OF LAUNDRY)	(HOURS OF SERVICE)	(MEALS SERVED)	(FTE)	(NRSNG FTES)	(GROSS REV)
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	34,281						
009	LAUNDRY & LINEN SERVI	654	11,567					
010	HOUSEKEEPING	220		551				
011	DIETARY	4,325			8,163			
012	CAFETERIA			21		8,952		
014	NURSING ADMINISTRATIO	328				349	4,728	
017	MEDICAL RECORDS & LIB	917		24		460		21,744,786
018	SOCIAL SERVICE	347						
025	INPAT ROUTINE SRVC CN							
034	ADULTS & PEDIATRICS	5,237	4,742	126	8,163	1,769	1,769	1,576,179
	SKILLED NURSING FACIL							
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	5,616	1,431	90		381	381	998,972
040	ANESTHESIOLOGY	90						168,693
041	RADIOLOGY-DIAGNOSTIC	2,408	2,169	27		1,000		5,393,289
044	LABORATORY	1,294		31		969		4,705,009
049	RESPIRATORY THERAPY	1,517		45		497		1,881,593
050	PHYSICAL THERAPY	1,348	570	18		1		239,625
055	MEDICAL SUPPLIES CHAR	2,208				202		471,987
056	DRUGS CHARGED TO PATI	930		6		256		1,844,213
059	SNF PT							
	OUTPAT SERVICE COST C							
060	CLINIC	1,139	85			390		960,045
061	EMERGENCY	2,006	2,570	69		1,384	1,384	3,505,181
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	3,697		94		1,194	1,194	
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	34,281	11,567	551	8,163	8,852	4,728	21,744,786
	NONREIMBURS COST CENT							
100	01 UNASSIGNED SPACE							
100	02 LEASED CLINICS							
100	03 MARKETING					100		
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED	554,185	59,798	313,326	677,252	87,886	599,935	370,717
	(WRKSHT B, PART I)							
104	UNIT COST MULTIPLIER		5.169707		82.966066		126.889805	
	(WRKSHT B, PT I)							
105	COST TO BE ALLOCATED	16.165952		568.649728		9.817471		.017049
	(WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER							
	(WRKSHT B, PT II)							
107	COST TO BE ALLOCATED	70,161	7,533	5,107	61,801	774	8,257	17,126
	(WRKSHT B, PART III)							
108	UNIT COST MULTIPLIER		.651249		7.570869		1.746404	
	(WRKSHT B, PT III)							
		2.046644		9.268603		.086461		.000788

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET B-1  
 I I TO 6/30/2008 I

COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT )
GENERAL SERVICE COST	18
003 NEW CAP REL COSTS-BLD	
004 NEW CAP REL COSTS-MVB	
005 EMPLOYEE BENEFITS	
006 ADMINISTRATIVE & GENE	
007 MAINTENANCE & REPAIRS	
008 OPERATION OF PLANT	
009 LAUNDRY & LINEN SERVI	
010 HOUSEKEEPING	
011 DIETARY	
012 CAFETERIA	
014 NURSING ADMINISTRATIO	
017 MEDICAL RECORDS & LIB	
018 SOCIAL SERVICE	100
INPAT ROUTINE SRVC CN	
025 ADULTS & PEDIATRICS	100
034 SKILLED NURSING FACIL	
ANCILLARY SRVC COST C	
037 OPERATING ROOM	
040 ANESTHESIOLOGY	
041 RADIOLOGY-DIAGNOSTIC	
044 LABORATORY	
049 RESPIRATORY THERAPY	
050 PHYSICAL THERAPY	
055 MEDICAL SUPPLIES CHAR	
056 DRUGS CHARGED TO PATI	
059 SNF PT	
OUTPAT SERVICE COST C	
060 CLINIC	
061 EMERGENCY	
062 OBSERVATION BEDS (NON	
063 OTHER OUTPATIENT SERV	
063 50 RURAL HEALTH CLINIC	
SPEC PURPOSE COST CEN	
095 SUBTOTALS	100
NONREIMBURS COST CENT	
100 01 UNASSIGNED SPACE	
100 02 LEASED CLINICS	
100 03 MARKETING	
101 CROSS FOOT ADJUSTMENT	
102 NEGATIVE COST CENTER	
103 COST TO BE ALLOCATED	14,822
(PER WRKSHT B, PART	
104 UNIT COST MULTIPLIER	
(WRKSHT B, PT I)	148.220000
105 COST TO BE ALLOCATED	
(PER WRKSHT B, PART	
106 UNIT COST MULTIPLIER	
(WRKSHT B, PT II)	
107 COST TO BE ALLOCATED	3,793
(PER WRKSHT B, PART	
108 UNIT COST MULTIPLIER	
(WRKSHT B, PT III)	37.930000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,624,287		2,624,287		2,624,287
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	3,579,841		3,579,841		3,579,841
37	OPERATING ROOM	761,027		761,027		761,027
40	ANESTHESIOLOGY	12,144		12,144		12,144
41	RADIOLOGY-DIAGNOSTIC	1,244,747		1,244,747		1,244,747
44	LABORATORY	889,307		889,307		889,307
49	RESPIRATORY THERAPY	529,557		529,557		529,557
50	PHYSICAL THERAPY	298,615		298,615		298,615
55	MEDICAL SUPPLIES CHARGED	937,005		937,005		937,005
56	DRUGS CHARGED TO PATIENTS	744,646		744,646		744,646
59	SNF PT OUTPAT SERVICE COST CNTRS					
60	CLINIC	519,150		519,150		519,150
61	EMERGENCY	1,759,081		1,759,081		1,759,081
62	OBSERVATION BEDS (NON-DIS	429,331		429,331		429,331
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	1,439,236		1,439,236		1,439,236
101	SUBTOTAL	15,767,974		15,767,974		15,767,974
102	LESS OBSERVATION BEDS	429,331		429,331		429,331
103	TOTAL	15,338,643		15,338,643		15,338,643

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
	ADULTS & PEDIATRICS	1,364,715		1,364,715			
34	SKILLED NURSING FACILITY	3,249,077		3,249,077			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	32,050	966,922	998,972	.761810	.761810	.761810
40	ANESTHESIOLOGY	5,452	102,722	108,174	.112264	.112264	.112264
41	RADIOLOGY-DIAGNOSTIC	376,648	5,016,640	5,393,288	.230796	.230796	.230796
44	LABORATORY	531,591	4,173,418	4,705,009	.189013	.189013	.189013
49	RESPIRATORY THERAPY	373,869	1,227,157	1,601,026	.330761	.330761	.330761
50	PHYSICAL THERAPY	41,994	197,631	239,625	1.246176	1.246176	1.246176
55	MEDICAL SUPPLIES CHARGED	267,737	484,815	752,552	1.245103	1.245103	1.245103
56	DRUGS CHARGED TO PATIENTS	800,645	1,043,567	1,844,212	.403775	.403775	.403775
59	SNF PT	748,376		748,376			
	OUTPAT SERVICE COST CNTRS						
60	CLINIC		960,045	960,045	.540756	.540756	.540756
61	EMERGENCY	64,967	3,440,213	3,505,180	.501852	.501852	.501852
62	OBSERVATION BEDS (NON-DIS		211,464	211,464	2.030279	2.030279	2.030279
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC		912,697	912,697	1.576904	1.576904	1.576904
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	7,857,121	18,737,291	26,594,412			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,857,121	18,737,291	26,594,412			

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	2,624,287		2,624,287		2,624,287
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	3,579,841		3,579,841		3,579,841
37	OPERATING ROOM	761,027		761,027		761,027
40	ANESTHESIOLOGY	12,144		12,144		12,144
41	RADIOLOGY-DIAGNOSTIC	1,244,747		1,244,747		1,244,747
44	LABORATORY	889,307		889,307		889,307
49	RESPIRATORY THERAPY	529,557		529,557		529,557
50	PHYSICAL THERAPY	298,615		298,615		298,615
55	MEDICAL SUPPLIES CHARGED	937,005		937,005		937,005
56	DRUGS CHARGED TO PATIENTS	744,646		744,646		744,646
59	SNF PT OUTPAT SERVICE COST CNTRS					
60	CLINIC	519,150		519,150		519,150
61	EMERGENCY	1,759,081		1,759,081		1,759,081
62	OBSERVATION BEDS (NON-DIS	429,331		429,331		429,331
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS	1,439,236		1,439,236		1,439,236
101	SUBTOTAL	15,767,974		15,767,974		15,767,974
102	LESS OBSERVATION BEDS	429,331		429,331		429,331
103	TOTAL	15,338,643		15,338,643		15,338,643

COMPUTATION OF RATIO OF COSTS TO CHARGES  
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS	1,364,715		1,364,715			
34	SKILLED NURSING FACILITY ANCILLARY SRVC COST CNTRS	3,249,077		3,249,077			
37	OPERATING ROOM	32,050	966,922	998,972	.761810	.761810	.761810
40	ANESTHESIOLOGY	5,452	102,722	108,174	.112264	.112264	.112264
41	RADIOLOGY-DIAGNOSTIC	376,648	5,016,640	5,393,288	.230796	.230796	.230796
44	LABORATORY	531,591	4,173,418	4,705,009	.189013	.189013	.189013
49	RESPIRATORY THERAPY	373,869	1,227,157	1,601,026	.330761	.330761	.330761
50	PHYSICAL THERAPY	41,994	197,631	239,625	1.246176	1.246176	1.246176
55	MEDICAL SUPPLIES CHARGED	267,737	484,815	752,552	1.245103	1.245103	1.245103
56	DRUGS CHARGED TO PATIENTS	800,645	1,043,567	1,844,212	.403775	.403775	.403775
59	SNF PT	748,376		748,376			
60	OUTPAT SERVICE COST CNTRS CLINIC		960,045	960,045	.540756	.540756	.540756
61	EMERGENCY	64,967	3,440,213	3,505,180	.501852	.501852	.501852
62	OBSERVATION BEDS (NON-DIS		211,464	211,464	2.030279	2.030279	2.030279
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS		912,697	912,697	1.576904	1.576904	1.576904
101	SUBTOTAL	7,857,121	18,737,291	26,594,412			
102	LESS OBSERVATION BEDS						
103	TOTAL	7,857,121	18,737,291	26,594,412			

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

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	761,027	90,160	670,867			761,027
40	ANESTHESIOLOGY	12,144	1,382	10,762			12,144
41	RADIOLOGY-DIAGNOSTIC	1,244,747	187,355	1,057,392			1,244,747
44	LABORATORY	889,307	49,474	839,833			889,307
49	RESPIRATORY THERAPY	529,557	24,977	504,580			529,557
50	PHYSICAL THERAPY	298,615	17,863	280,752			298,615
55	MEDICAL SUPPLIES CHARGED	937,005	31,555	905,450			937,005
56	DRUGS CHARGED TO PATIENTS	744,646	16,662	727,984			744,646
59	SNF PT						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	519,150	16,657	502,493			519,150
61	EMERGENCY	1,759,081	45,131	1,713,950			1,759,081
62	OBSERVATION BEDS (NON-DIS	429,331		429,331			429,331
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	1,439,236	58,304	1,380,932			1,439,236
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,563,846	539,520	9,024,326			9,563,846
102	LESS OBSERVATION BEDS	429,331		429,331			429,331
103	TOTAL	9,134,515	539,520	8,594,995			9,134,515

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	998,972	.761810	.761810
40	ANESTHESIOLOGY	108,174	.112264	.112264
41	RADIOLOGY-DIAGNOSTIC	5,393,288	.230796	.230796
44	LABORATORY	4,705,009	.189013	.189013
49	RESPIRATORY THERAPY	1,601,026	.330761	.330761
50	PHYSICAL THERAPY	239,625	1.246176	1.246176
55	MEDICAL SUPPLIES CHARGED	752,552	1.245103	1.245103
56	DRUGS CHARGED TO PATIENTS	1,844,212	.403775	.403775
59	SNF PT	748,376		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	960,045	.540756	.540756
61	EMERGENCY	3,505,180	.501852	.501852
62	OBSERVATION BEDS (NON-DIS	211,464	2.030279	2.030279
63	OTHER OUTPATIENT SERVICE			
50 63	RURAL HEALTH CLINIC	912,697	1.576904	1.576904
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,980,620		
102	LESS OBSERVATION BEDS	211,464		
103	TOTAL	21,769,156		

Health Financial Systems MCRIF32 FOR FRANKLIN HOSPITAL  
 CALCULATION OF OUTPATIENT SERVICE COST TO  
 CHARGE RATIOS NET OF REDUCTIONS  
 SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART II

\*\*NOT A CMS WORKSHEET \*\* (09/2000)

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	761,027	90,160	670,867			761,027
40	ANESTHESIOLOGY	12,144	1,382	10,762			12,144
41	RADIOLOGY-DIAGNOSTIC	1,244,747	187,355	1,057,392			1,244,747
44	LABORATORY	889,307	49,474	839,833			889,307
49	RESPIRATORY THERAPY	529,557	24,977	504,580			529,557
50	PHYSICAL THERAPY	298,615	17,863	280,752			298,615
55	MEDICAL SUPPLIES CHARGED	937,005	31,555	905,450			937,005
56	DRUGS CHARGED TO PATIENTS	744,646	16,662	727,984			744,646
59	SNF PT						
	OUTPAT SERVICE COST CNTRS						
60	CLINIC	519,150	16,657	502,493			519,150
61	EMERGENCY	1,759,081	45,131	1,713,950			1,759,081
62	OBSERVATION BEDS (NON-DIS	429,331		429,331			429,331
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC	1,439,236	58,304	1,380,932			1,439,236
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	9,563,846	539,520	9,024,326			9,563,846
102	LESS OBSERVATION BEDS	429,331		429,331			429,331
103	TOTAL	9,134,515	539,520	8,594,995			9,134,515

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	998,972	.761810	.761810
40	ANESTHESIOLOGY	108,174	.112264	.112264
41	RADIOLOGY-DIAGNOSTIC	5,393,288	.230796	.230796
44	LABORATORY	4,705,009	.189013	.189013
49	RESPIRATORY THERAPY	1,601,026	.330761	.330761
50	PHYSICAL THERAPY	239,625	1.246176	1.246176
55	MEDICAL SUPPLIES CHARGED	752,552	1.245103	1.245103
56	DRUGS CHARGED TO PATIENTS	1,844,212	.403775	.403775
59	SNF PT	748,376		
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	960,045	.540756	.540756
61	EMERGENCY	3,505,180	.501852	.501852
62	OBSERVATION BEDS (NON-DIS	211,464	2.030279	2.030279
63	OTHER OUTPATIENT SERVICE			
63	RURAL HEALTH CLINIC	912,697	1.576904	1.576904
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	21,980,620		
102	LESS OBSERVATION BEDS	211,464		
103	TOTAL	21,769,156		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
 I I TO 6/30/2008 I PART III

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	761,027	998,972			
40	ANESTHESIOLOGY	12,144	108,174			
41	RADIOLOGY-DIAGNOSTIC	1,244,747	5,393,288			
44	LABORATORY	889,307	4,705,009			
49	RESPIRATORY THERAPY	529,557	1,601,026			
50	PHYSICAL THERAPY	298,615	239,625			
55	MEDICAL SUPPLIES CHARGED	937,005	752,552			
56	DRUGS CHARGED TO PATIENTS	744,646	1,844,212			
59	SNF PT		748,376			
	OUTPAT SERVICE COST CNTRS					
60	CLINIC	519,150	960,045			
61	EMERGENCY	1,759,081	3,505,180			
62	OBSERVATION BEDS (NON-DIS	429,331	211,464			
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	1,439,236	912,697			
	OTHER REIMBURS COST CNTRS					
101	TOTAL	9,563,846	21,980,620			

COMPUTATION OF OUTPATIENT COST PER VISIT -  
RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET C  
I I TO 6/30/2008 I PART V

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT- PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT- PATIENT COSTS 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM	761,027	12,000	773,027	998,972			
40	ANESTHESIOLOGY	12,144	87,628	99,772	108,174			
41	RADIOLOGY-DIAGNOSTIC	1,244,747		1,244,747	5,393,288			
44	LABORATORY	889,307	33,782	923,089	4,705,009			
49	RESPIRATORY THERAPY	529,557	36,000	565,557	1,601,026			
50	PHYSICAL THERAPY	298,615		298,615	239,625			
55	MEDICAL SUPPLIES CHARGED	937,005		937,005	752,552			
56	DRUGS CHARGED TO PATIENTS	744,646		744,646	1,844,212			
59	SNF PT				748,376			
60	OUTPAT SERVICE COST CNTRS							
	CLINIC	519,150		519,150	960,045			
61	EMERGENCY	1,759,081	823,677	2,582,758	3,505,180			
62	OBSERVATION BEDS (NON-DIS	429,331		429,331	211,464			
63	OTHER OUTPATIENT SERVICE							
63	50 RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	8,124,610	993,087	9,117,697	21,067,923			
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							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Cost/Charge	Cost/Charge	Cost/Charge	Outpatient	Outpatient
	Ratio (C, Pt I, col. 9)	Ratio (C, Pt I, col. 9)	Ratio (C, Pt II, col. 9)	Ambulatory Surgical Ctr	Radiology
	1	1.01	1.02	2	3
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM	.761810		.761810		
40 ANESTHESIOLOGY	.112264		.112264		
41 RADIOLOGY-DIAGNOSTIC	.230796		.230796		
44 LABORATORY	.189013		.189013		
49 RESPIRATORY THERAPY	.330761		.330761		
50 PHYSICAL THERAPY	1.246176		1.246176		
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103		1.245103		
56 DRUGS CHARGED TO PATIENTS	.403775		.403775		
59 SNF PT					
60 OUTPAT SERVICE COST CNTRS					
CLINIC	.540756		.540756		
61 EMERGENCY	.501852		.501852		
62 OBSERVATION BEDS (NON-DISTINCT PART)	2.030279		2.030279		
63 OTHER OUTPATIENT SERVICE COST CENTER					
50 RURAL HEALTH CLINIC					
101 SUBTOTAL					
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES					

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

TITLE XVIII, PART B

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radiology 7	Other Outpatient Diagnostic 8
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		571,729			
40 ANESTHESIOLOGY					
41 RADIOLOGY-DIAGNOSTIC		1,849,423			
44 LABORATORY		1,825,957			
49 RESPIRATORY THERAPY		545,181			
50 PHYSICAL THERAPY		49,904			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		275,343			
56 DRUGS CHARGED TO PATIENTS		526,260			
59 SNF PT					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC		921,360			
62 EMERGENCY		1,122,680			
63 OBSERVATION BEDS (NON-DISTINCT PART)		161,374			
63 OTHER OUTPATIENT SERVICE COST CENTER					
50 63 RURAL HEALTH CLINIC					
101 SUBTOTAL		7,849,211			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES					
104 NET CHARGES		7,849,211			

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

TITLE XVIII, PART B

HOSPITAL

		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
Cost Center Description		9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	435,549		
40	ANESTHESIOLOGY			
41	RADIOLOGY-DIAGNOSTIC	426,839		
44	LABORATORY	345,130		
49	RESPIRATORY THERAPY	180,325		
50	PHYSICAL THERAPY	62,189		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	342,830		
56	DRUGS CHARGED TO PATIENTS	212,491		
59	SNF PT			
OUTPAT SERVICE COST CNTRS				
60	CLINIC	498,231		
61	EMERGENCY	563,419		
62	OBSERVATION BEDS (NON-DISTINCT PART)	327,634		
63	OTHER OUTPATIENT SERVICE COST CENTER			
50 63	RURAL HEALTH CLINIC			
101	SUBTOTAL	3,394,637		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	3,394,637		

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/21/2008
I	14-1321	I	FROM 7/ 1/2007	I	WORKSHEET D
I	COMPONENT NO:	I	TO 6/30/2008	I	PART VI
I	14-1321	I		I	

- 1 DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES
- 2 PROGRAM VACCINE CHARGES
- 3 PROGRAM COSTS

1  
.403775

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART II  
 I 14-6088 I I

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART II  
 I 14-6088 I

TITLE XVIII, PART A SKILLED NURSING FACILITY

PPS

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

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
37	ANCILLARY SRVC COST CNTRS							
	OPERATING ROOM			998,972				
40	ANESTHESIOLOGY			108,174				
41	RADIOLOGY-DIAGNOSTIC			5,393,288			29,465	
44	LABORATORY			4,705,009			83,377	
49	RESPIRATORY THERAPY			1,601,026				
50	PHYSICAL THERAPY			239,625				
55	MEDICAL SUPPLIES CHARGED			752,552				
56	DRUGS CHARGED TO PATIENTS			1,844,212			197,197	
59	SNF PT			748,376			726,299	
	OUTPAT SERVICE COST CNTRS							
60	CLINIC			960,045				
61	EMERGENCY			3,505,180				
62	OBSERVATION BEDS (NON-DIS			211,464				
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			21,067,923			1,036,338	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

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	.761810				
40 ANESTHESIOLOGY	.112264				81,331
41 RADIOLOGY-DIAGNOSTIC	.230796				21,497
44 LABORATORY	.189013				1,261,744
49 RESPIRATORY THERAPY	.330761				911,794
50 PHYSICAL THERAPY	1.246176				206,044
55 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103				52,176
56 DRUGS CHARGED TO PATIENTS	.403775				85,921
59 SNF PT					207,637
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC	.540756				
61 EMERGENCY	.501852				
62 OBSERVATION BEDS (NON-DISTINCT PART)	2.030279				1,096,196
63 OTHER OUTPATIENT SERVICE COST CENTER					34,938
63 50 RURAL HEALTH CLINIC	1.576904				
101 SUBTOTAL					
102 CRNA CHARGES					3,959,278
103 LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104 NET CHARGES					3,959,278

(A) WORKSHEET A LINE NUMBERS

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
(A) 37 ANCILLARY SRVC COST CNTRS	5.01	5.02	5.03	6	7
40 OPERATING ROOM					
41 ANESTHESIOLOGY					
44 RADIOLOGY-DIAGNOSTIC					
49 LABORATORY					
50 RESPIRATORY THERAPY					
55 PHYSICAL THERAPY					
56 MEDICAL SUPPLIES CHARGED TO PATIENTS					
59 DRUGS CHARGED TO PATIENTS					
60 SNF PT					
61 OUTPAT SERVICE COST CNTRS					
62 CLINIC					
63 EMERGENCY					
63 50 OBSERVATION BEDS (NON-DISTINCT PART)					
101 OTHER OUTPATIENT SERVICE COST CENTER					
102 RURAL HEALTH CLINIC					
103 SUBTOTAL					
104 CRNA CHARGES					
LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
NET CHARGES					

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D  
 I COMPONENT NO: I TO 6/30/2008 I PART V  
 I 14-1321 I I

TITLE XIX - O/P

HOSPITAL

Cost Center Description	Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	8	9	9.01	9.02	9.03
(A) ANCILLARY SRVC COST CNTRS					
37 OPERATING ROOM		61,959			
40 ANESTHESIOLOGY		2,413			
41 RADIOLOGY-DIAGNOSTIC		291,205			
44 LABORATORY		172,341			
49 RESPIRATORY THERAPY		68,151			
50 PHYSICAL THERAPY		65,020			
55 MEDICAL SUPPLIES CHARGED TO PATIENTS		106,980			
56 DRUGS CHARGED TO PATIENTS		83,839			
59 SNF PT					
60 OUTPAT SERVICE COST CNTRS					
61 CLINIC					
61 EMERGENCY		550,128			
62 OBSERVATION BEDS (NON-DISTINCT PART)		70,934			
63 OTHER OUTPATIENT SERVICE COST CENTER					
63 50 RURAL HEALTH CLINIC					
101 SUBTOTAL		1,472,970			
102 CRNA CHARGES					
103 LESS PBP CLINIC LAB SVCS-					
PROGRAM ONLY CHARGES					
104 NET CHARGES		1,472,970			

(A) WORKSHEET A LINE NUMBERS

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART I  
 I 14-1321 I I

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)	1,956
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,886
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	1,886
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	35
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)	35
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,366
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	35
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)	35
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,624,287
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	93,916
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,530,371

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,364,715
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,364,715
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.854139
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	723.60
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	2,530,371

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART II  
 I 14-1321 I

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					1,341.66
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,832,708
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					1,832,708

	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  
735,923  
2,568,631

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	46,958
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	46,958
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	93,916
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART III  
 I 14-1321 I I

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	320
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1,341.66
85	OBSERVATION BED COST	429,331

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART I  
 I 14-6088 I I

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	25,820
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	25,820
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	25,820
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	6,693
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,579,841
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,579,841

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,279,268
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,279,268
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.091659
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	127.00
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,579,841

COMPUTATION OF INPATIENT OPERATING COST

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-1  
 I COMPONENT NO: I TO 6/30/2008 I PART III  
 I 14-6088 I I

TITLE XVIII PART A

SNF

PPS

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

66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1 3,579,841
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	138.65
68	PROGRAM ROUTINE SERVICE COST	927,984
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	927,984
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	927,984
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	927,984
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	927,984
80	PROGRAM INPATIENT ANCILLARY SERVICES	102,182
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	1,030,166

PART IV - COMPUTATION OF OBSERVATION BED COST

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

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-1321 I I

TITLE XVIII, PART A HOSPITAL

OTHER

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		1,045,138	
37	ANCILLARY SRVC COST CNTRS			
40	OPERATING ROOM	.761810	13,445	10,243
41	ANESTHESIOLOGY	.112264		
44	RADIOLOGY-DIAGNOSTIC	.230796	236,280	54,532
49	LABORATORY	.189013	372,914	70,486
50	RESPIRATORY THERAPY	.330761	301,706	99,793
55	PHYSICAL THERAPY	1.246176	29,170	36,351
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103	194,664	242,377
59	DRUGS CHARGED TO PATIENTS SNF PT	.403775	550,041	222,093
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC	.540756		
62	EMERGENCY	.501852	96	48
63	OBSERVATION BEDS (NON-DISTINCT PART)	2.030279		
63	OTHER OUTPATIENT SERVICE COST CENTER			
50	RURAL HEALTH CLINIC			
101	OTHER REIMBURS COST CNTRS			
102	TOTAL		1,698,316	735,923
103	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,698,316	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-2321 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	.761810		
40	ANESTHESIOLOGY	.112264		
41	RADIOLOGY-DIAGNOSTIC	.230796	1,612	372
44	LABORATORY	.189013	7,265	1,373
49	RESPIRATORY THERAPY	.330761	8,465	2,800
50	PHYSICAL THERAPY	1.246176	5,620	7,004
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103	9,475	11,797
56	DRUGS CHARGED TO PATIENTS	.403775	22,121	8,932
59	SNF PT			
	OUTPAT SERVICE COST CNTRS			
60	CLINIC	.540756		
61	EMERGENCY	.501852		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.030279		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		54,558	32,278
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		54,558	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-6088 I I

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
37	ANCILLARY SRVC COST CNTRS OPERATING ROOM	.761810		
40	ANESTHESIOLOGY	.112264		
41	RADIOLOGY-DIAGNOSTIC	.230796	29,465	6,800
44	LABORATORY	.189013	83,377	15,759
49	RESPIRATORY THERAPY	.330761		
50	PHYSICAL THERAPY	1.246176		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103		
56	DRUGS CHARGED TO PATIENTS	.403775	197,197	79,623
59	SNF PT		726,299	
60	OUTPAT SERVICE COST CNTRS CLINIC	.540756		
61	EMERGENCY	.501852		
62	OBSERVATION BEDS (NON-DISTINCT PART)	2.030279		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC OTHER REIMBURS COST CNTRS			
101	TOTAL		1,036,338	102,182
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,036,338	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET D-4  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-1321 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		88,693	
37	ANCILLARY SRVC COST CNTRS			
40	OPERATING ROOM	.761810	1,798	1,370
41	ANESTHESIOLOGY	.112264		
44	RADIOLOGY-DIAGNOSTIC	.230796	31,627	7,299
49	LABORATORY	.189013	54,622	10,324
50	RESPIRATORY THERAPY	.330761	31,170	10,310
55	PHYSICAL THERAPY	1.246176	268	334
56	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.245103	5,446	6,781
59	DRUGS CHARGED TO PATIENTS	.403775	28,849	11,649
	SNF PT			
60	OUTPAT SERVICE COST CNTRS			
61	CLINIC	.540756		
62	EMERGENCY	.501852	27,155	13,628
63	OBSERVATION BEDS (NON-DISTINCT PART)	2.030279		
63	OTHER OUTPATIENT SERVICE COST CENTER			
50	RURAL HEALTH CLINIC	1.576904		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		180,935	61,695
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		180,935	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET E  
 I COMPONENT NO: I TO 6/30/2008 I PART B  
 I 14-1321 I I

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1 MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS) 3,394,637  
 1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1,  
 2001 (SEE INSTRUCTIONS).  
 1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.  
 1.03 ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.  
 1.04 LINE 1.01 TIMES LINE 1.03.  
 1.05 LINE 1.02 DIVIDED BY LINE 1.04.  
 1.06 TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)  
 1.07 ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9,  
 9.01, 9.02) LINE 101.  
 2 INTERNS AND RESIDENTS  
 3 ORGAN ACQUISITIONS  
 4 COST OF TEACHING PHYSICIANS  
 5 TOTAL COST (SEE INSTRUCTIONS) 3,394,637

COMPUTATION OF LESSER OF COST OR CHARGES

REASONABLE CHARGES  
 6 ANCILLARY SERVICE CHARGES  
 7 INTERNS AND RESIDENTS SERVICE CHARGES  
 8 ORGAN ACQUISITION CHARGES  
 9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.  
 10 TOTAL REASONABLE CHARGES  
 CUSTOMARY CHARGES  
 11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR  
 PAYMENT FOR SERVICES ON A CHARGE BASIS  
 12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE  
 FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT  
 BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).  
 13 RATIO OF LINE 11 TO LINE 12  
 14 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)  
 15 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST  
 16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES  
 17 LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC) 3,428,583  
 17.01 TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)

COMPUTATION OF REIMBURSEMENT SETTLEMENT

18 CAH DEDUCTIBLES 45,843  
 18.01 CAH ACTUAL BILLED COINSURANCE 1,201,511  
 LINE 17.01 (SEE INSTRUCTIONS)  
 19 SUBTOTAL (SEE INSTRUCTIONS) 2,181,229  
 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 2,181,229  
 24 PRIMARY PAYER PAYMENTS 561  
 25 SUBTOTAL 2,180,668

REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)

26 COMPOSITE RATE ESRD  
 27 BAD DEBTS (SEE INSTRUCTIONS) 226,286  
 27.01 ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS) 226,286  
 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES  
 28 SUBTOTAL 2,406,954  
 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 2,406,954  
 33 SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)  
 34 INTERIM PAYMENTS 2,020,565  
 34.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)  
 35 BALANCE DUE PROVIDER/PROGRAM 386,389  
 36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)  
 IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET E-1  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-1321 I I

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
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.		2,088,279		2,020,565
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)		NONE		NONE
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
SUBTOTAL				
4 TOTAL INTERIM PAYMENTS		NONE		NONE
TO BE COMPLETED BY INTERMEDIARY		2,088,279		2,020,565
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
SUBTOTAL				
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		NONE		NONE
7 TOTAL MEDICARE PROGRAM LIABILITY				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				

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

TITLE XVIII SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,838,645		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER .01				
ADJUSTMENTS TO PROVIDER .02				
ADJUSTMENTS TO PROVIDER .03				
ADJUSTMENTS TO PROVIDER .04				
ADJUSTMENTS TO PROVIDER .05				
ADJUSTMENTS TO PROGRAM .50				
ADJUSTMENTS TO PROGRAM .51				
ADJUSTMENTS TO PROGRAM .52				
ADJUSTMENTS TO PROGRAM .53				
ADJUSTMENTS TO PROGRAM .54				
ADJUSTMENTS TO PROGRAM .99				
SUBTOTAL		NONE		NONE
4 TOTAL INTERIM PAYMENTS		1,838,645		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER .01				
TENTATIVE TO PROVIDER .02				
TENTATIVE TO PROVIDER .03				
TENTATIVE TO PROGRAM .50				
TENTATIVE TO PROGRAM .51				
TENTATIVE TO PROGRAM .52				
TENTATIVE TO PROGRAM .99				
SUBTOTAL		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)				
SETTLEMENT TO PROVIDER .01				
SETTLEMENT TO PROGRAM .02				
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

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

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

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

IN LIEU OF FORM CMS-2552-96 (11/1998)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET E-1  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-2321 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		115,748		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER		.01		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS			NONE	NONE
			115,748	
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		
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			NONE	NONE
SETTLEMENT TO PROVIDER		.01		
SETTLEMENT TO PROGRAM		.02		
7 TOTAL MEDICARE PROGRAM LIABILITY				

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

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

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT  
SWING BEDS

IN LIEU OF FORM CMS-2552-96-E-2 (05/2004)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I  
 I COMPONENT NO: I TO 6/30/2008 I WORKSHEET E-2  
 I 14-Z321 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)	94,855	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	32,601	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	70	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	127,456	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	127,456	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	127,456	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,244	
14	80% OF PART B COSTS		
15	SUBTOTAL	126,212	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	126,212	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	115,748	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	10,464	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1321	I FROM 7/ 1/2007	I WORKSHEET E-3
I COMPONENT NO:	I TO 6/30/2008	I PART II
I 14-1321	I	I

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	2,568,631
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	2,568,631
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	2,594,317
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE 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	2,594,317
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	268,057
21	EXCESS REASONABLE COST	
22	SUBTOTAL	2,326,260
23	COINSURANCE	2,304
24	SUBTOTAL	2,323,956
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	29,231
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	29,231
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	2,353,187
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER 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	2,353,187
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	2,088,279
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	264,908
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET E-3  
 I COMPONENT NO: I TO 6/30/2008 I PART III  
 I 14-6088 I I

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

	TITLE XVIII	SNF	PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2	
COMPUTATION OF NET COST OF COVERED SERVICE					
1	INPATIENT HOSPITAL/SNF/NF SERVICES				
2	MEDICAL AND OTHER SERVICES				
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)				
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)				
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)				
6	SUBTOTAL				
7	INPATIENT PRIMARY PAYER PAYMENTS				
8	OUTPATIENT PRIMARY PAYER PAYMENTS				
9	SUBTOTAL				
COMPUTATION OF LESSER OF COST OR CHARGES					
REASONABLE CHARGES					
10	ROUTINE SERVICE CHARGES				
11	ANCILLARY SERVICE CHARGES				
12	INTERNS AND RESIDENTS SERVICE CHARGES				
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE				
14	TEACHING PHYSICIANS				
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION				
16	TOTAL REASONABLE CHARGES				
CUSTOMARY CHARGES					
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				
19	RATIO OF LINE 17 TO LINE 18				
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)				
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				
23	COST OF COVERED SERVICES				
PROSPECTIVE PAYMENT AMOUNT					
24	OTHER THAN OUTLIER PAYMENTS				2,455,294
25	OUTLIER PAYMENTS				
26	PROGRAM CAPITAL PAYMENTS				
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)				
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS				
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS				
30	SUBTOTAL				2,455,294
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)				
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30				2,455,294
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)				
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
34	EXCESS OF REASONABLE COST				
35	SUBTOTAL				2,455,294
36	COINSURANCE				593,352
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19				
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)				89,159
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)				
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES				
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)				62,411
39	UTILIZATION REVIEW				
40	SUBTOTAL (SEE INSTRUCTIONS)				1,924,353
41	INPATIENT ROUTINE SERVICE COST				
42	MEDICARE INPATIENT ROUTINE CHARGES				
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES				
45	RATIO OF LINE 43 TO 44				
46	TOTAL CUSTOMARY CHARGES				
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST				
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION				
50	OTHER ADJUSTMENTS (SPECIFY)				
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS				
52	SUBTOTAL				1,924,353
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)				
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS				
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER				1,924,353
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)				
57	INTERIM PAYMENTS				1,838,645
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)				
58	BALANCE DUE PROVIDER/PROGRAM				85,708

CALCULATION OF REIMBURSEMENT SETTLEMENT

IN LIEU OF FORM CMS-2552-96-E-3 (5/2008)  
I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET E-3  
I COMPONENT NO: I TO 6/30/2008 I PART III  
I 14-6088 I I

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

TITLE XVIII

SNF

PPS  
TITLE V OR  
TITLE XIX  
1

TITLE XVIII  
SNF PPS  
2

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

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I  
 I I TO 6/30/2008 I WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	112,494			
2	TEMPORARY INVESTMENTS	75,546			
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	6,960,376			
5	OTHER RECEIVABLES	1,173,070			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,458,677			
7	INVENTORY	230,239			
8	PREPAID EXPENSES	97,332			
9	OTHER CURRENT ASSETS	738,698			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	5,929,078			
FIXED ASSETS					
12	LAND				
12.01	LAND IMPROVEMENTS				
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	16,340,680			
14.01	LESS ACCUMULATED DEPRECIATION	-13,209,343			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	3,131,337			
OTHER ASSETS					
22	INVESTMENTS				
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	66,511			
26	TOTAL OTHER ASSETS	66,511			
27	TOTAL ASSETS	9,126,926			

BALANCE SHEET

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I  
 I I TO 6/30/2008 I WORKSHEET G

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,903,196			
29 SALARIES, WAGES & FEES PAYABLE	627,194			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	679,181			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	845,886			
35 OTHER CURRENT LIABILITIES	625,166			
36 TOTAL CURRENT LIABILITIES	4,680,623			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	3,592,616			
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	3,592,616			
43 TOTAL LIABILITIES	8,273,239			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	853,687			
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	853,687			
52 TOTAL LIABILITIES AND FUND BALANCES	9,126,926			

STATEMENT OF CHANGES IN FUND BALANCES

GENERAL FUND

SPECIFIC PURPOSE FUND

1 2

3 4

1	FUND BALANCE AT BEGINNING	1,322,128
	OF PERIOD	
2	NET INCOME (LOSS)	-454,538
3	TOTAL	867,590
4	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)	
5	ADDITIONS (CREDIT ADJUSTM	
6		
7		
8		
9		
10	TOTAL ADDITIONS	
11	SUBTOTAL	867,590
12	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)	
13	DEDUCTIONS (DEBIT ADJUSTM	13,903
14		
15		
16		
17		
18	TOTAL DEDUCTIONS	13,903
19	FUND BALANCE AT END OF	853,687
	PERIOD PER BALANCE SHEET	

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: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET G-2  
 I I TO 6/30/2008 I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
1 00 GENERAL INPATIENT ROUTINE CARE SERVICES			
4 00 HOSPITAL	1,364,715		1,364,715
5 00 SWING BED - SNF			
5 00 SWING BED - NF			
6 00 SKILLED NURSING FACILITY	3,279,268		3,279,268
9 00 TOTAL GENERAL INPATIENT ROUTINE CARE	4,643,983		4,643,983
15 00 INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
16 00 TOTAL INTENSIVE CARE TYPE INPAT HOSP	4,643,983		4,643,983
17 00 TOTAL INPATIENT ROUTINE CARE SERVICE	3,217,006	17,881,247	21,098,253
18 00 ANCILLARY SERVICES			
18 00 OUTPATIENT SERVICES			
18 50 RURAL HEALTH CLINIC	73,401	839,296	912,697
24 00 PRO FEES	21,060	2,030,507	2,051,567
25 00 TOTAL PATIENT REVENUES	7,955,450	20,751,050	28,706,500

PART II-OPERATING EXPENSES

26 00 OPERATING EXPENSES		17,433,490	
ADD (SPECIFY)			
27 00 BAD DEBT			
28 00			
29 00			
30 00			
31 00			
32 00			
33 00 TOTAL ADDITIONS			
DEDUCT (SPECIFY)			
34 00 DEDUCT (SPECIFY)			
35 00			
36 00			
37 00			
38 00			
39 00 TOTAL DEDUCTIONS			
40 00 TOTAL OPERATING EXPENSES		17,433,490	

## STATEMENT OF REVENUES AND EXPENSES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED 11/21/2008
I	14-1321	I	FROM 7/ 1/2007	I	WORKSHEET G-3
I		I	TO 6/30/2008	I	

## DESCRIPTION

1	TOTAL PATIENT REVENUES	28,706,500
2	LESS: ALLOWANCES AND DISCOUNTS ON	13,357,239
3	NET PATIENT REVENUES	15,349,261
4	LESS: TOTAL OPERATING EXPENSES	17,433,490
5	NET INCOME FROM SERVICE TO PATIENT	-2,084,229
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S	
	TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS, FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER (SPECIFY)	927,279
24.01		702,412
25	TOTAL OTHER INCOME	1,629,691
26	TOTAL	-454,538
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIO	-454,538

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

IN LIEU OF FORM CMS-2552-96 M-1 (11/1998)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET M-1  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-3469 I I

RHC 1

	COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATION 4
FACILITY HEALTH CARE STAFF COSTS				
1				
2	214,502		214,502	
3	79,629		79,629	
4	120,574		120,574	
5				
6	162,482		162,482	
7				
8				
9				
10	577,187		577,187	
COSTS UNDER AGREEMENT				
11				
12				
13				
14				
OTHER HEALTH CARE COSTS				
15				
16				
17				
18				
19				
20				
21				
22	577,187		577,187	
COSTS OTHER THAN RHC/FQHC SERVICES				
23				
24				
25				
26				
27				
28				
FACILITY OVERHEAD				
29				
30	98,595	75,661	174,256	-11,732
31	98,595	75,661	174,256	-11,732
32	675,782	75,661	751,443	-11,732

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

IN LIEU OF FORM CMS-2552-96 M-1 (11/1998)  
 I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET M-1  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-3469 I I

RHC 1

	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
1 FACILITY HEALTH CARE STAFF COSTS			
2 PHYSICIAN	214,502		214,502
3 PHYSICIAN ASSISTANT	79,629		79,629
4 NURSE PRACTITIONER	120,574		120,574
5 VISITING NURSE			
6 OTHER NURSE	162,482		162,482
7 CLINICAL PSYCHOLOGIST			
8 CLINICAL SOCIAL WORKER			
9 LABORATORY TECHNICIAN			
9 OTHER FACILITY HEALTH CARE STAFF COSTS			
10 SUBTOTAL (SUM OF LINES 1-9)	577,187		577,187
11 COSTS UNDER AGREEMENT			
12 PHYSICIAN SERVICES UNDER AGREEMENT			
13 PHYSICIAN SUPERVISION UNDER AGREEMENT			
13 OTHER COSTS UNDER AGREEMENT			
14 SUBTOTAL (SUM OF LINES 11-13)			
15 OTHER HEALTH CARE COSTS			
16 MEDICAL SUPPLIES			
16 TRANSPORTATION (HEALTH CARE STAFF)			
17 DEPRECIATION-MEDICAL EQUIPMENT			
18 PROFESSIONAL LIABILITY INSURANCE			
19 OTHER HEALTH CARE COSTS			
20 ALLOWABLE GME COSTS			
21 SUBTOTAL (SUM OF LINES 15-20)			
22 TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	577,187		577,187
23 COSTS OTHER THAN RHC/FQHC SERVICES			
24 PHARMACY			
24 DENTAL			
25 OPTOMETRY			
26 ALL OTHER NONREIMBURSABLE COSTS			
27 NONALLOWABLE GME COSTS			
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
29 FACILITY OVERHEAD			
30 FACILITY COSTS			
30 ADMINISTRATIVE COSTS	162,524		162,524
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	162,524		162,524
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	739,711		739,711

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1321	I FROM 7/ 1/2007	I WORKSHEET M-2
I COMPONENT NO:	I TO 6/30/2008	I
I 14-3469	I	I

## RHC 1

## VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4	
POSITIONS					
1	PHYSICIANS	1.10	4,808	4,200	4,620
2	PHYSICIAN ASSISTANTS	.88	1,410	2,100	1,848
3	NURSE PRACTITIONERS	1.19	4,052	2,100	2,499
4	SUBTOTAL (SUM OF LINES 1-3)	3.17	10,270		8,967
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	3.17	10,270		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES					
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	577,187			
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)				
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	577,187			
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000			
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	162,524			
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	699,525			
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	862,049			
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)				
18	SUBTRACT LINE 17 FROM LINE 16	862,049			
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	862,049			
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	1,439,236			

ALLOCATION OF OVERHEAD  
TO RHC/FQHC SERVICES

I PROVIDER NO:	I PERIOD:	I PREPARED 11/21/2008
I 14-1321	I FROM 7/ 1/2007	I WORKSHEET M-2
I COMPONENT NO:	I TO 6/30/2008	I
I 14-3469	I	I

RHC 1

VISITS AND PRODUCTIVITY

GREATER OF  
COL. 2 OR  
COL. 4  
5

1	POSITIONS	
2	PHYSICIANS	
3	PHYSICIAN ASSISTANTS	
4	NURSE PRACTITIONERS	
5	SUBTOTAL (SUM OF LINES 1-3)	10,270
6	VISITING NURSE	
7	CLINICAL PSYCHOLOGIST	
8	CLINICAL SOCIAL WORKER	
9	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	10,270
	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

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
I 14-1321 I FROM 7/ 1/2007 I WORKSHEET M-3  
I COMPONENT NO: I TO 6/30/2008 I  
I 14-3469 I I

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)	1,439,236
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	1,439,236
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	10,270
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	10,270
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	140.14

CALCULATION OF LIMIT (1)

	PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	140.14
10	CALCULATION OF SETTLEMENT PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)	2,821
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)	395,335
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)*	395,335
16.01	PRIMARY PAYER AMOUNT	
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)	28,752
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)	366,583
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)	293,266
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)	
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)	293,266
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
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)	293,266
25	INTERIM PAYMENTS	143,137
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)	150,129
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.

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

I PROVIDER NO: I PERIOD: I PREPARED 11/21/2008  
 I 14-1321 I FROM 7/ 1/2007 I WORKSHEET M-5  
 I COMPONENT NO: I TO 6/30/2008 I  
 I 14-3469 I 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.			143,137
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			NONE
	ADJUSTMENTS TO PROVIDER	.01		
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	ADJUSTMENTS TO PROGRAM	.99		
	SUBTOTAL			NONE
4	TOTAL INTERIM PAYMENTS			143,137
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	TENTATIVE TO PROGRAM	.99		
	SUBTOTAL			NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)			
	SETTLEMENT TO PROVIDER	.01		
	SETTLEMENT TO PROGRAM	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY			

NAME OF INTERMEDIARY:  
 INTERMEDIARY NO:

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

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

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