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

FORM APPROVED
OMB NO. 0938-0050

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1323	PERIOD FROM 4/ 1/2007 TO 3/31/2008	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 8/15/2008 TIME 11:39

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
MASSAC MEMORIAL HOSPITAL 14-1323
FOR THE COST REPORTING PERIOD BEGINNING 4/ 1/2007 AND ENDING 3/31/2008 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

____
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

____
TITLE

____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII A	TITLE XVIII B	TITLE XIX
		1	2	3	4
1	HOSPITAL	0	32,855	584,901	0
3	SWING BED - SNF	0	-23,141	0	0
9	RHC	0	0	-412	0
100	TOTAL	0	9,714	584,489	0

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 28 CHICK STREET P.O. BOX:
1.01 CITY: METROPOLIS STATE: IL ZIP CODE: 62960- COUNTY: MASSAC

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	MASSAC MEMORIAL HOSPITAL	14-1323		2/ 1/2003	N	O	O
04.00	SWING BED - SNF	MASSAC MEMORIAL HOSPITAL	14-Z323		2/ 1/2003	N	O	N
14.00	HOSPITAL-BASED RHC	MASSAC MEMORIAL MEDICAL CLINIC	14-3478		2/ 7/2006	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 4/ 1/2007 TO: 3/31/2008

		1	2
18	TYPE OF CONTROL	11	

TYPE OF HOSPITAL/SUBPROVIDER

		1
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. Y

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

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

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

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

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

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

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

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

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

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

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE. / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2.

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

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

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

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

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

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

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

26 IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0

26.01 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

26.02 ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /

27 DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2. Y 2/ 1/2003

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

Line	Description	1	2	3	4
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)	0	0.0000	0.0000	
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00	0		

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

Line	Category	%	Y/N
28.03	STAFFING	0.00%	
28.04	RECRUITMENT	0.00%	
28.05	RETENTION	0.00%	
28.06	TRAINING	0.00%	

Line	Question	Answer
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	Y
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	

MISCELLANEOUS COST REPORT INFORMATION

Line	Question	Answer
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)?	
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

Line	Question	V 1	XVIII 2	XIX 3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?			

TITLE XIX INPATIENT SERVICES

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

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

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

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

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
PREMIUMS: 263,438
PAID LOSSES: 0
AND/OR SELF INSURANCE: 0
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	-------- I/P DAYS / O/P VISITS / TRIPS -------- TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	19	8,030	89,743.58		2,739		223
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF					986		
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	19	8,030	89,743.58		3,725		223
6	INTENSIVE CARE UNIT	6	2,190	4,351.48		337		20
12	TOTAL	25	10,220	94,095.06		4,062		243
13	RPCH VISITS							
24	RURAL HEALTH CLINIC					369		2,868
25	TOTAL	25						
26	OBSERVATION BED DAYS							73
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	---------- I/P DAYS / TITLE XIX OBSERVATION BEDS ADMITTED 5.01	NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS ------------ TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			3,487				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			991				
4	ADULTS & PED-SB NF			28				
5	TOTAL ADULTS AND PEDS			4,506				
6	INTENSIVE CARE UNIT			461				
12	TOTAL			4,967				
13	RPCH VISITS							
24	RURAL HEALTH CLINIC			4,321				
25	TOTAL							
26	OBSERVATION BED DAYS		73	404	1	403		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

	COMPONENT	I & R FTES NET 9	--- FULL TIME EQUIV --- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	--------------- DISCHARGES ------------------ TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					723	71	939
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
12	TOTAL		176.95			723	71	939
13	RPCH VISITS							
24	RURAL HEALTH CLINIC		3.07					
25	TOTAL		180.02					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO: 14-1323 COMPONENT NO: 14-3478	PERIOD: FROM 4/ 1/2007 TO 3/31/2008	PREPARED 8/15/2008 WORKSHEET S-8

RHC 1

CLINIC ADDRESS AND IDENTIFICATION

1 STREET: 28 CHICK STREET
1.01 CITY: METROPOLIS STATE: IL ZIP CODE: 62960 COUNTY: MASSAC
2 DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN R

SOURCE OF FEDERAL FUNDS:

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

PHYSICIAN INFORMATION:

		PHYSICIAN NAME	BILLING NUMBER
9	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DEBRA KESTER	P52323
9.01	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	DR. MICHAEL KLOEP	F50864
9.02	PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	BRIAN JOHNSTON	Q46148

		PHYSICIAN NAME	HOURS OF SUPERVISION
10	SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	DR. MICHAEL KLOEP	355.00

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

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			830	1630	830	1630	830	1630	830	1630	830	1630		

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

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

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

15 PROVIDER NAME: PROVIDER NUMBER:

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: I 14-1323 I PERIOD: I FROM 4/ 1/2007 I TO 3/31/2008 I PREPARED 8/15/2008 WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		187,137	187,137	-1,173	185,964
3.01	0301	NEW CAP REL COSTS-BLDG AMBULANCE				26,000	26,000
3.02	0302	NEW CAP REL COSTS-BLDG EKG				15,459	15,459
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		630,457	630,457	421,242	1,051,699
5	0500	EMPLOYEE BENEFITS	100,326	2,513,515	2,613,841		2,613,841
6	0600	ADMINISTRATIVE & GENERAL	1,048,383	1,292,473	2,340,856	-93,124	2,247,732
8	0800	OPERATION OF PLANT	253,638	531,231	784,869	-22,188	762,681
9	0900	LAUNDRY & LINEN SERVICE	58,365	30,698	89,063		89,063
10	1000	HOUSEKEEPING	233,850	53,251	287,101		287,101
11	1100	DIETARY	240,512	154,637	395,149	-170,406	224,743
12	1200	CAFETERIA				169,218	169,218
14	1400	NURSING ADMINISTRATION	437,054	17,096	454,150		454,150
17	1700	MEDICAL RECORDS & LIBRARY	189,442	26,111	215,553		215,553
18	1800	SOCIAL SERVICE	135,641	12,329	147,970		147,970
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	898,637	186,736	1,085,373		1,085,373
26	2600	INTENSIVE CARE UNIT	501,243	18,059	519,302	-6,877	512,425
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	219,963	400,698	620,661	-26,542	594,119
41	4100	RADIOLOGY-DIAGNOSTIC	472,073	782,707	1,254,780	-314,778	940,002
44	4400	LABORATORY	391,682	563,983	955,665	-26,860	928,805
49	4900	RESPIRATORY THERAPY	291,356	82,518	373,874	-20,909	352,965
50	5000	PHYSICAL THERAPY	364,932	14,936	379,868	-32,352	347,516
53	5300	ELECTROCARDIOLOGY	95,637	169,060	264,697	3,744	268,441
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,491	13,726	72,217	100,078	172,295
56	5600	DRUGS CHARGED TO PATIENTS	155,397	421,996	577,393	-13,168	564,225
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	457,229	1,268,022	1,725,251	44,886	1,770,137
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	151,082	72,004	223,086	6,811	229,897
		OTHER REIMBURS COST CNTRS					
65	6500	AMBULANCE SERVICES	487,690	99,830	587,520	-35,266	552,254
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		42,314	42,314	-42,314	
90	9000	OTHER CAPITAL RELATED COSTS		46,147	46,147	-46,147	
95		SUBTOTALS	7,242,623	9,631,671	16,874,294	-64,666	16,809,628
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	41,028	9,809	50,837	64,666	115,503
98.01	9801	PROMOTION					
99	9900	NONPAID WORKERS					
101		TOTAL	7,283,651	9,641,480	16,925,131	-0-	16,925,131

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-3,949	182,015
3.01	0301	NEW CAP REL COSTS-BLDG AMBULANCE		26,000
3.02	0302	NEW CAP REL COSTS-BLDG EKG		15,459
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-38,916	1,012,783
5	0500	EMPLOYEE BENEFITS	-194	2,613,647
6	0600	ADMINISTRATIVE & GENERAL	-120,555	2,127,177
8	0800	OPERATION OF PLANT	-2,789	759,892
9	0900	LAUNDRY & LINEN SERVICE		89,063
10	1000	HOUSEKEEPING		287,101
11	1100	DIETARY		224,743
12	1200	CAFETERIA	-64,295	104,923
14	1400	NURSING ADMINISTRATION		454,150
17	1700	MEDICAL RECORDS & LIBRARY	-3,215	212,338
18	1800	SOCIAL SERVICE		147,970
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-81,219	1,004,154
26	2600	INTENSIVE CARE UNIT		512,425
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-219,745	374,374
41	4100	RADIOLOGY-DIAGNOSTIC		940,002
44	4400	LABORATORY		928,805
49	4900	RESPIRATORY THERAPY		352,965
50	5000	PHYSICAL THERAPY		347,516
53	5300	ELECTROCARDIOLOGY	-83,950	184,491
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	-12,621	159,674
56	5600	DRUGS CHARGED TO PATIENTS	-6,949	557,276
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-664,469	1,105,668
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		229,897
		OTHER REIMBURS COST CNTRS		
65	6500	AMBULANCE SERVICES	-14,305	537,949
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-1,317,171	15,492,457
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
98	9800	PHYSICIANS' PRIVATE OFFICES		115,503
98.01	9801	PROMOTION		
99	9900	NONPAID WORKERS		
101		TOTAL	-1,317,171	15,607,960

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	
3.01	NEW CAP REL COSTS-BLDG AMBULANCE	0301	NEW CAP REL COSTS-BLDG & FIXT
3.02	NEW CAP REL COSTS-BLDG EKG	0302	NEW CAP REL COSTS-BLDG & FIXT
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
65	AMBULANCE SERVICES	6500	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
98.01	PROMOTION	9801	PHYSICIANS' PRIVATE OFFICES
99	NONPAID WORKERS	9900	
101	TOTAL	0000	

	EXPLANATION OF RECLASSIFICATION	INCREASE CODE (1) 1	COST CENTER 2	LINE NO 3	SALARY 4	OTHER 5
1	TO RECLASS INTEREST EXPENSE	A	NEW CAP REL COSTS-BLDG & FIXT	3		3,949
2			NEW CAP REL COSTS-MVBLE EQUIP	4		38,365
3	TO RECLASS CAFETERIA EXPENSE	B	CAFETERIA	12	102,997	66,221
4	TO RECLASS RENTAL EXPENSE	C	NEW CAP REL COSTS-MVBLE EQUIP	4		371,300
5						
6						
7						
8	TO RECLASS MEDICAL SUPPLY EXPENSE	D	MEDICAL SUPPLIES CHARGED TO PATIENTS	55		100,078
9						
10						
11						
12						
13						
14						
15						
16						
17	TO RECLASS DRUG COSTS	E	DRUGS CHARGED TO PATIENTS	56		1,188
18	TO RECLASS PROF BUILD COSTS	F	PHYSICIANS' PRIVATE OFFICES	98		39,692
19						
20	TO RECLASS EKG SALARIES	G	ELECTROCARDIOLOGY	53	19,203	
21	TO RECLASS PROFESSIONAL BUILDING CST	J	PHYSICIANS' PRIVATE OFFICES	98	9,826	11,232
22	TO RECLASS REAL ESTATE TAXES	M	PHYSICIANS' PRIVATE OFFICES	98		3,916
23	TO RECLASS ER PHY MALPRACTICE	N	EMERGENCY	61		82,397
24	TO RECLASS AMBULANCE RENTAL EXPENSE	O	NEW CAP REL COSTS-BLDG AMBULANCE	3.01		26,000
25	TO RECLASS SLEEP LAB RENTAL EXPENSE	P	NEW CAP REL COSTS-BLDG EKG	3.02		15,459
26	RHC PHYSICIAN RECRUITMENT	T	RURAL HEALTH CLINIC	63.50		6,811
36	TOTAL RECLASSIFICATIONS				132,026	766,608

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

	EXPLANATION OF RECLASSIFICATION	CODE (1) 1	COST CENTER 6	LINE NO 7	SALARY 8	OTHER 9	A-7 REF 10
			DECREASE				
1	TO RECLASS INTEREST EXPENSE	A	INTEREST EXPENSE	88		42,314	11
2							11
3	TO RECLASS CAFETERIA EXPENSE	B	DIETARY	11	102,997	66,221	
4	TO RECLASS RENTAL EXPENSE	C	OPERATION OF PLANT	8		1,130	10
5			RADIOLOGY-DIAGNOSTIC	41		311,035	
6			LABORATORY	44		26,783	
7			PHYSICAL THERAPY	50		32,352	
8	TO RECLASS MEDICAL SUPPLY EXPENSE	D	INTENSIVE CARE UNIT	26		6,877	
9			OPERATING ROOM	37		26,067	
10			RADIOLOGY-DIAGNOSTIC	41		3,743	
11			LABORATORY	44		77	
12			OPERATING ROOM	37		475	
13			RESPIRATORY THERAPY	49		1,706	
14			EMERGENCY	61		37,511	
15			AMBULANCE SERVICES	65		9,266	
16			DRUGS CHARGED TO PATIENTS	56		14,356	
17	TO RECLASS DRUG COSTS	E	DIETARY	11		1,188	
18	TO RECLASS PROF BUILD COSTS	F	NEW CAP REL COSTS-BLDG & FIXT	3		37,687	9
19			NEW CAP REL COSTS-MVBLE EQUIP	4		2,005	9
20	TO RECLASS EKG SALARIES	G	RESPIRATORY THERAPY	49	19,203		
21	TO RECLASS PROFESSIONAL BUILDING CST	J	OPERATION OF PLANT	8	9,826	11,232	
22	TO RECLASS REAL ESTATE TAXES	M	ADMINISTRATIVE & GENERAL	6		3,916	
23	TO RECLASS ER PHY MALPRACTICE	N	ADMINISTRATIVE & GENERAL	6		82,397	
24	TO RECLASS AMBULANCE RENTAL EXPENSE	O	AMBULANCE SERVICES	65		26,000	10
25	TO RECLASS SLEEP LAB RENTAL EXPENSE	P	ELECTROCARDIOLOGY	53		15,459	10
26	RHC PHYSICIAN RECRUITMENT	T	ADMINISTRATIVE & GENERAL	6		6,811	
36	TOTAL RECLASSIFICATIONS				132,026	766,608	

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

RECLASS CODE: A
EXPLANATION : TO RECLASS INTEREST EXPENSE

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	3,949	INTEREST EXPENSE	88	42,314
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4	38,365			0
TOTAL RECLASSIFICATIONS FOR CODE A			42,314			42,314

RECLASS CODE: B
EXPLANATION : TO RECLASS CAFETERIA EXPENSE

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	169,218	DIETARY	11	169,218
TOTAL RECLASSIFICATIONS FOR CODE B			169,218			169,218

RECLASS CODE: C
EXPLANATION : TO RECLASS RENTAL EXPENSE

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	371,300	OPERATION OF PLANT	8	1,130
2.00			0	RADIOLOGY-DIAGNOSTIC	41	311,035
3.00			0	LABORATORY	44	26,783
4.00			0	PHYSICAL THERAPY	50	32,352
TOTAL RECLASSIFICATIONS FOR CODE C			371,300			371,300

RECLASS CODE: D
EXPLANATION : TO RECLASS MEDICAL SUPPLY EXPENSE

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	55	100,078	INTENSIVE CARE UNIT	26	6,877
2.00			0	OPERATING ROOM	37	26,067
3.00			0	RADIOLOGY-DIAGNOSTIC	41	3,743
4.00			0	LABORATORY	44	77
5.00			0	OPERATING ROOM	37	475
6.00			0	RESPIRATORY THERAPY	49	1,706
7.00			0	EMERGENCY	61	37,511
8.00			0	AMBULANCE SERVICES	65	9,266
9.00			0	DRUGS CHARGED TO PATIENTS	56	14,356
TOTAL RECLASSIFICATIONS FOR CODE D			100,078			100,078

RECLASS CODE: E
EXPLANATION : TO RECLASS DRUG COSTS

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	56	1,188	DIETARY	11	1,188
TOTAL RECLASSIFICATIONS FOR CODE E			1,188			1,188

RECLASS CODE: F
EXPLANATION : TO RECLASS PROF BUILD COSTS

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	98	39,692	NEW CAP REL COSTS-BLDG & FIXT	3	37,687
2.00			0	NEW CAP REL COSTS-MVBLE EQUIP	4	2,005
TOTAL RECLASSIFICATIONS FOR CODE F			39,692			39,692

RECLASS CODE: G
EXPLANATION : TO RECLASS EKG SALARIES

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	19,203	RESPIRATORY THERAPY	49	19,203
TOTAL RECLASSIFICATIONS FOR CODE G			19,203			19,203

RECLASS CODE: J
EXPLANATION : TO RECLASS PROFESSIONAL BUILDING CST

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	98	21,058	OPERATION OF PLANT	8	21,058
TOTAL RECLASSIFICATIONS FOR CODE J			21,058			21,058

RECLASS CODE: M
EXPLANATION : TO RECLASS REAL ESTATE TAXES

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	98	3,916	ADMINISTRATIVE & GENERAL	6	3,916
TOTAL RECLASSIFICATIONS FOR CODE M			3,916			3,916

RECLASS CODE: N
EXPLANATION : TO RECLASS ER PHY MALPRACTICE

LINE	INCREASE COST CENTER	LINE	AMOUNT	DECREASE COST CENTER	LINE	AMOUNT
1.00	EMERGENCY	61	82,397	ADMINISTRATIVE & GENERAL	6	82,397
TOTAL RECLASSIFICATIONS FOR CODE N			82,397			82,397

RECLASS CODE: O
EXPLANATION : TO RECLASS AMBULANCE RENTAL EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG AMBULAN	3.01	26,000	AMBULANCE SERVICES	65	26,000
TOTAL RECLASSIFICATIONS FOR CODE O			26,000			26,000

RECLASS CODE: P
EXPLANATION : TO RECLASS SLEEP LAB RENTAL EXPENSE

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-BLDG EKG	3.02	15,459	ELECTROCARDIOLOGY	53	15,459
TOTAL RECLASSIFICATIONS FOR CODE P			15,459			15,459

RECLASS CODE: T
EXPLANATION : RHC PHYSICIAN RECRUITMENT

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	RURAL HEALTH CLINIC	63.50	6,811	ADMINISTRATIVE & GENERAL	6	6,811
TOTAL RECLASSIFICATIONS FOR CODE T			6,811			6,811

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

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

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	13,981					13,981	
2	LAND IMPROVEMENTS	173,980					173,980	
3	BUILDINGS & FIXTURE	8,837,045	7,375,694		7,375,694		16,212,739	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	6,456,109	378,012		378,012		6,834,121	
7	SUBTOTAL	15,481,115	7,753,706		7,753,706		23,234,821	
8	RECONCILING ITEMS							
9	TOTAL	15,481,115	7,753,706		7,753,706		23,234,821	

PART III - RECONCILIATION OF CAPITAL COST CENTERS

*	DESCRIPTION	GROSS ASSETS 1	CAPITLIZED LEASES 2	GROSS ASSETS FOR RATIO 3	RATIO 4	INSURANCE 5	TAXES 6	OTHER CAPITAL RELATED COSTS 7	TOTAL 8
		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
3	NEW CAP REL COSTS-BL	16,386,719		16,386,719	.705690	32,565			32,565
3 01	NEW CAP REL COSTS-BL								
3 02	NEW CAP REL COSTS-BL								
4	NEW CAP REL COSTS-MV	6,834,121		6,834,121	.294310	13,582			13,582
5	TOTAL	23,220,840		23,220,840	1.000000	46,147			46,147

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
3	NEW CAP REL COSTS-BL	149,450			32,565			182,015
3 01	NEW CAP REL COSTS-BL		26,000					26,000
3 02	NEW CAP REL COSTS-BL		15,459					15,459
4	NEW CAP REL COSTS-MV	627,901	371,300		13,582			1,012,783
5	TOTAL	777,351	412,759		46,147			1,236,257

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

SUMMARY OF OLD AND NEW CAPITAL

*	DESCRIPTION	DEPRECIATION 9	LEASE 10	INTEREST 11	INSURANCE 12	TAXES 13	OTHER CAPITAL RELATED COST 14	TOTAL (1) 15
3	NEW CAP REL COSTS-BL	187,137						187,137
3 01	NEW CAP REL COSTS-BL							
3 02	NEW CAP REL COSTS-BL							
4	NEW CAP REL COSTS-MV	630,457						630,457
5	TOTAL	817,594						817,594

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

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES	B	-3,949	NEW CAP REL COSTS-BLDG &	3	11
4	INVESTMENT INCOME-NEW MOVABLE EQUIP	B	-38,365	NEW CAP REL COSTS-MVBLE E	4	11
5	INVESTMENT INCOME-OTHER					
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-10,759	ADMINISTRATIVE & GENERAL	6	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-785,745			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1				
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS					
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	A	-3,215	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	TELEVISION	A	-2,789	OPERATION OF PLANT	8	
38	OTHER OPERATING REVENUE	B	-5,911	ADMINISTRATIVE & GENERAL	6	
39	OTHER NON OPERATING REVENUE	B	-19,954	ADMINISTRATIVE & GENERAL	6	
40	ACCOUNTS PAYABLE DISCOUNT	B	-623	ADMINISTRATIVE & GENERAL	6	
41	PHARMACY REBATES	B	-6,949	DRUGS CHARGED TO PATIENTS	56	
42	PURCHASING REBATES	B	-12,621	MEDICAL SUPPLIES CHARGED	55	
43	DIETARY REVENUE	B	-64,295	CAFETERIA	12	
44	AMBULANCE SERVICE	B	-14,305	AMBULANCE SERVICES	65	
45	OTHER ADJUSTMENTS (SPECIFY)					
46	LOBBYING EXPENSE	A	-9,205	ADMINISTRATIVE & GENERAL	6	
47	CRNA EXPENSES	A	-219,745	OPERATING ROOM	37	
48						
49	COMMUNITY OUTREACH	A	-12,703	ADMINISTRATIVE & GENERAL	6	
49.01						
49.02	PATIENT PHONE SALARY	A	-708	ADMINISTRATIVE & GENERAL	6	
49.03	PATIENT PHONE BENEFITS	A	-194	EMPLOYEE BENEFITS	5	
49.04	PATIENT PHONE DEPRECIATION	A	-551	NEW CAP REL COSTS-MVBLE E	4	9
49.05	ER PHYSICIAN MALPRACTICE	A	-43,893	EMERGENCY	61	
49.06						
49.07	MARKETING EXPENSE	A	-60,692	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,317,171			

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

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN- ERATION 3	PROFES- SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	44	LABORATORY	12,000		12,000				
3	53	EKG	83,950	83,950					
4	61	EMERGENCY	1,164,964	620,576	544,388				
5	25	HOSPITALIST	81,219	81,219					
6	53	CARDIAC REHAB	12,000		12,000				
7	53	SLEEP LAB	43,278		43,278				
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	1,397,411	785,745	611,666				

	WKSHT A LINE NO. 10	COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	44	LABORATORY							
3	53	EKG							83,950
4	61	EMERGENCY							620,576
5	25	HOSPITALIST							81,219
6	53	CARDIAC REHAB							
7	53	SLEEP LAB							
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							785,745

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
3.01	NEW CAP REL COSTS-BLDG AMBULANCE	4	SQUARE	FEET	ENTERED
3.02	NEW CAP REL COSTS-BLDG EKG	5	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	6	SQUARE	FEET	ENTERED
5	EMPLOYEE BENEFITS	S	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	-8	ACCUM.	COST	NOT ENTERED
8	OPERATION OF PLANT	10	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	11	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	12	TIME	SPENT	ENTERED
11	DIETARY	13	MEALS	SERVED	ENTERED
12	CAFETERIA	14	FTE		ENTERED
14	NURSING ADMINISTRATION	16	NURSING	FTES	ENTERED
17	MEDICAL RECORDS & LIBRARY	19	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	20	ASSIGNEDTI	IMES	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-BLDG AM	NEW CAP REL COSTS-BLDG EK	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL
			0	3	3.01	3.02	4	5	5a.00
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	182,015	182,015					
003	01	NEW CAP REL COSTS-BLDG AM	26,000		26,000				
003	02	NEW CAP REL COSTS-BLDG EK	15,459			15,459			
004		NEW CAP REL COSTS-MVBLE E	1,012,783				1,012,783		
005		EMPLOYEE BENEFITS	2,613,647	1,583			8,178	2,623,408	
006		ADMINISTRATIVE & GENERAL	2,127,177	30,202			156,069	382,881	2,696,329
008		OPERATION OF PLANT	759,892	34,576			178,674	89,042	1,062,184
009		LAUNDRY & LINEN SERVICE	89,063	4,547			23,494	21,315	138,419
010		HOUSEKEEPING	287,101	1,664			8,599	85,404	382,768
011		DIETARY	224,743	4,925			25,452	50,222	305,342
012		CAFETERIA	104,923	2,384			12,319	37,615	157,241
014		NURSING ADMINISTRATION	454,150	1,935			10,000	159,616	625,701
017		MEDICAL RECORDS & LIBRARY	212,338	4,310		1,808	25,166	69,186	312,808
018		SOCIAL SERVICE	147,970					49,537	197,507
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,004,154	29,369			151,762	328,189	1,513,474
026		INTENSIVE CARE UNIT	512,425	5,243			27,093	183,058	727,819
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	374,374	19,256			99,503	80,332	573,465
041		RADIOLOGY-DIAGNOSTIC	940,002	12,445			64,307	172,405	1,189,159
044		LABORATORY	928,805	4,042			20,888	143,045	1,096,780
049		RESPIRATORY THERAPY	352,965	2,632			13,599	99,392	468,588
050		PHYSICAL THERAPY	347,516	5,887			30,422	133,276	517,101
053		ELECTROCARDIOLOGY	184,491			13,651	21,837	41,940	261,919
055		MEDICAL SUPPLIES CHARGED	159,674					21,361	181,035
056		DRUGS CHARGED TO PATIENTS	557,276	1,752			9,051	56,752	624,831
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	1,105,668	7,566			39,096	166,984	1,319,314
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	229,897	7,347			37,967	55,176	330,387
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	537,949		26,000		47,500	178,108	789,557
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	15,492,457	181,665	26,000	15,459	1,010,976	2,604,836	15,471,728
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP		350			1,807		2,157
098		PHYSICIANS' PRIVATE OFFIC	115,503					18,572	134,075
098	01	PROMOTION							
099		NONPAID WORKERS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	15,607,960	182,015	26,000	15,459	1,012,783	2,623,408	15,607,960

		COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
			6	8	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-BLDG AM							
003	02	NEW CAP REL COSTS-BLDG EK							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL	2,696,329						
008		OPERATION OF PLANT	221,815	1,283,999					
009		LAUNDRY & LINEN SERVICE	28,906	50,233	217,558				
010		HOUSEKEEPING	79,933	18,387		481,088			
011		DIETARY	63,764	54,419	688	17,411	441,624		
012		CAFETERIA	32,836	26,340		20,321		236,738	
014		NURSING ADMINISTRATION	130,665	21,381				16,791	794,538
017		MEDICAL RECORDS & LIBRARY	65,323	53,807		4,834		12,972	
018		SOCIAL SERVICE	41,245					4,565	
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	316,065	324,485	147,185	160,821	390,576	51,952	358,618
026		INTENSIVE CARE UNIT	151,990	57,929	4,213	38,946	19,611	21,839	188,099
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	119,756	212,749	10,122	17,132		10,711	43,272
041		RADIOLOGY-DIAGNOSTIC	248,331	137,497	4,413	33,192		22,058	
044		LABORATORY	229,039	44,662		30,317		22,234	
049		RESPIRATORY THERAPY	97,855	29,077	3,562	20,928		14,596	
050		PHYSICAL THERAPY	107,986	65,045	4,198	10,123		12,445	
053		ELECTROCARDIOLOGY	54,696		5,707	18,372		4,873	23,192
055		MEDICAL SUPPLIES CHARGED	37,805					4,499	
056		DRUGS CHARGED TO PATIENTS	130,483	19,353		3,492		6,980	
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	275,511	83,593	34,377	58,483		20,390	160,613
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	68,994	81,178	1,530	27,913		6,738	20,744
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	164,882						
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	2,667,880	1,280,135	215,995	462,285	410,187	233,643	794,538
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP	450	3,864					
098		PHYSICIANS' PRIVATE OFFIC	27,999		1,563	18,803	31,437	3,095	
098	01	PROMOTION							
099		NONPAID WORKERS							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	2,696,329	1,283,999	217,558	481,088	441,624	236,738	794,538

		COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST POST STEP-DOWN ADJ 26	TOTAL 27
		GENERAL SERVICE COST CNTR					
003		NEW CAP REL COSTS-BLDG &					
003	01	NEW CAP REL COSTS-BLDG AM					
003	02	NEW CAP REL COSTS-BLDG EK					
004		NEW CAP REL COSTS-MVBLE E					
005		EMPLOYEE BENEFITS					
006		ADMINISTRATIVE & GENERAL					
008		OPERATION OF PLANT					
009		LAUNDRY & LINEN SERVICE					
010		HOUSEKEEPING					
011		DIETARY					
012		CAFETERIA					
014		NURSING ADMINISTRATION					
017		MEDICAL RECORDS & LIBRARY	449,744				
018		SOCIAL SERVICE		243,317			
		INPAT ROUTINE SRVC CNTRS					
025		ADULTS & PEDIATRICS	193,884	213,382	3,670,442	-9,892	3,660,550
026		INTENSIVE CARE UNIT	25,520	28,400	1,264,366		1,264,366
		ANCILLARY SRVC COST CNTRS					
037		OPERATING ROOM	16,240		1,003,447	-876	1,002,571
041		RADIOLOGY-DIAGNOSTIC			1,634,650		1,634,650
044		LABORATORY	51,702		1,474,734	11,018	1,485,752
049		RESPIRATORY THERAPY	51,702		686,308		686,308
050		PHYSICAL THERAPY			716,898		716,898
053		ELECTROCARDIOLOGY			368,759		368,759
055		MEDICAL SUPPLIES CHARGED			223,339		223,339
056		DRUGS CHARGED TO PATIENTS			785,139		785,139
		OUTPAT SERVICE COST CNTRS					
061		EMERGENCY	109,370	1,535	2,063,186	-250	2,062,936
062		OBSERVATION BEDS (NON-DIS					
063		OTHER OUTPATIENT SERVICE					
063	50	RURAL HEALTH CLINIC			537,484		537,484
		OTHER REIMBURS COST CNTRS					
065		AMBULANCE SERVICES			954,439		954,439
		SPEC PURPOSE COST CENTERS					
095		SUBTOTALS	448,418	243,317	15,383,191		15,383,191
		NONREIMBURS COST CENTERS					
096		GIFT, FLOWER, COFFEE SHOP			6,471		6,471
098		PHYSICIANS' PRIVATE OFFIC	1,326		218,298		218,298
098	01	PROMOTION					
099		NONPAID WORKERS					
101		CROSS FOOT ADJUSTMENT					
102		NEGATIVE COST CENTER					
103		TOTAL	449,744	243,317	15,607,960		15,607,960

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-BLDG AM	NEW CAP REL COSTS-BLDG EK	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS
		0	3	3.01	3.02	4	4a	5
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
003 01	NEW CAP REL COSTS-BLDG AM							
003 02	NEW CAP REL COSTS-BLDG EK							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		1,583			8,178	9,761	9,761
006	ADMINISTRATIVE & GENERAL		30,202			156,069	186,271	1,426
008	OPERATION OF PLANT		34,576			178,674	213,250	331
009	LAUNDRY & LINEN SERVICE		4,547			23,494	28,041	79
010	HOUSEKEEPING		1,664			8,599	10,263	318
011	DIETARY		4,925			25,452	30,377	187
012	CAFETERIA		2,384			12,319	14,703	140
014	NURSING ADMINISTRATION		1,935			10,000	11,935	594
017	MEDICAL RECORDS & LIBRARY		4,310		1,808	25,166	31,284	257
018	SOCIAL SERVICE							184
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		29,369			151,762	181,131	1,221
026	INTENSIVE CARE UNIT		5,243			27,093	32,336	681
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		19,256			99,503	118,759	299
041	RADIOLOGY-DIAGNOSTIC		12,445			64,307	76,752	642
044	LABORATORY		4,042			20,888	24,930	532
049	RESPIRATORY THERAPY		2,632			13,599	16,231	370
050	PHYSICAL THERAPY		5,887			30,422	36,309	496
053	ELECTROCARDIOLOGY				13,651	21,837	35,488	156
055	MEDICAL SUPPLIES CHARGED							79
056	DRUGS CHARGED TO PATIENTS		1,752			9,051	10,803	211
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY		7,566			39,096	46,662	621
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC		7,347			37,967	45,314	205
	OTHER REIMBURS COST CNTRS							
065	AMBULANCE SERVICES			26,000		47,500	73,500	663
	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS		181,665	26,000	15,459	1,010,976	1,234,100	9,692
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		350			1,807	2,157	
098	PHYSICIANS' PRIVATE OFFIC							69
098 01	PROMOTION							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		182,015	26,000	15,459	1,012,783	1,236,257	9,761

		COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
			6	8	9	10	11	12	14
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &							
003	01	NEW CAP REL COSTS-BLDG AM							
003	02	NEW CAP REL COSTS-BLDG EK							
004		NEW CAP REL COSTS-MVBLE E							
005		EMPLOYEE BENEFITS							
006		ADMINISTRATIVE & GENERAL	187,697						
008		OPERATION OF PLANT	15,441	229,022					
009		LAUNDRY & LINEN SERVICE	2,012	8,960	39,092				
010		HOUSEKEEPING	5,564	3,280		19,425			
011		DIETARY	4,439	9,707	124	703	45,537		
012		CAFETERIA	2,286	4,698		821		22,648	
014		NURSING ADMINISTRATION	9,096	3,814				1,606	27,045
017		MEDICAL RECORDS & LIBRARY	4,547	9,597		195		1,241	
018		SOCIAL SERVICE	2,871					437	
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	22,002	57,877	26,446	6,493	40,273	4,970	12,207
026		INTENSIVE CARE UNIT	10,580	10,333	757	1,573	2,022	2,089	6,403
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	8,336	37,947	1,819	692		1,025	1,473
041		RADIOLOGY-DIAGNOSTIC	17,287	24,525	793	1,340		2,110	
044		LABORATORY	15,944	7,966		1,224		2,127	
049		RESPIRATORY THERAPY	6,812	5,186	640	845		1,396	
050		PHYSICAL THERAPY	7,517	11,602	754	409		1,191	
053		ELECTROCARDIOLOGY	3,808		1,026	742		466	789
055		MEDICAL SUPPLIES CHARGED	2,632					430	
056		DRUGS CHARGED TO PATIENTS	9,083	3,452		141		668	
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	19,179	14,910	6,177	2,361		1,951	5,467
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	4,803	14,479	275	1,127		645	706
		OTHER REIMBURS COST CNTRS							
065		AMBULANCE SERVICES	11,478						
		SPEC PURPOSE COST CENTERS							
095		SUBTOTALS	185,717	228,333	38,811	18,666	42,295	22,352	27,045
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP	31	689					
098		PHYSICIANS' PRIVATE OFFIC	1,949		281	759	3,242	296	
098	01	PROMOTION							
099		NONPAID WORKERS							
101		CROSS FOOT ADJUSTMENTS							
102		NEGATIVE COST CENTER							
103		TOTAL	187,697	229,022	39,092	19,425	45,537	22,648	27,045

		COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
			17	18	25	26	27
		GENERAL SERVICE COST CNTR					
003		NEW CAP REL COSTS-BLDG &					
003	01	NEW CAP REL COSTS-BLDG AM					
003	02	NEW CAP REL COSTS-BLDG EK					
004		NEW CAP REL COSTS-MVBLE E					
005		EMPLOYEE BENEFITS					
006		ADMINISTRATIVE & GENERAL					
008		OPERATION OF PLANT					
009		LAUNDRY & LINEN SERVICE					
010		HOUSEKEEPING					
011		DIETARY					
012		CAFETERIA					
014		NURSING ADMINISTRATION					
017		MEDICAL RECORDS & LIBRARY	47,121				
018		SOCIAL SERVICE		3,492			
		INPAT ROUTINE SRVC CNTRS					
025		ADULTS & PEDIATRICS	20,314	3,062	375,996		375,996
026		INTENSIVE CARE UNIT	2,674	408	69,856		69,856
		ANCILLARY SRVC COST CNTRS					
037		OPERATING ROOM	1,701		172,051		172,051
041		RADIOLOGY-DIAGNOSTIC			123,449		123,449
044		LABORATORY	5,417		58,140		58,140
049		RESPIRATORY THERAPY	5,417		36,897		36,897
050		PHYSICAL THERAPY			58,278		58,278
053		ELECTROCARDIOLOGY			42,475		42,475
055		MEDICAL SUPPLIES CHARGED			3,141		3,141
056		DRUGS CHARGED TO PATIENTS			24,358		24,358
		OUTPAT SERVICE COST CNTRS					
061		EMERGENCY	11,459	22	108,809		108,809
062		OBSERVATION BEDS (NON-DIS					
063		OTHER OUTPATIENT SERVICE					
063	50	RURAL HEALTH CLINIC			67,554		67,554
		OTHER REIMBURS COST CNTRS					
065		AMBULANCE SERVICES			85,641		85,641
		SPEC PURPOSE COST CENTERS					
095		SUBTOTALS	46,982	3,492	1,226,645		1,226,645
		NONREIMBURS COST CENTERS					
096		GIFT, FLOWER, COFFEE SHOP			2,877		2,877
098		PHYSICIANS' PRIVATE OFFIC	139		6,735		6,735
098	01	PROMOTION					
099		NONPAID WORKERS					
101		CROSS FOOT ADJUSTMENTS					
102		NEGATIVE COST CENTER					
103		TOTAL	47,121	3,492	1,236,257		1,236,257

	I PROVIDER NO:	I PERIOD:	I PREPARED 8/15/2008
COST ALLOCATION - STATISTICAL BASIS	I 14-1323	I FROM 4/ 1/2007	I WORKSHEET B-1
	I	I TO 3/31/2008	I

		COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-BLDG AM	NEW CAP REL COSTS-BLDG EK	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	
			(SQUARE FEET	(SQUARE)FEET	(SQUARE)FEET	(SQUARE)FEET	(GROSS) SALARIES	RECONCIL-) IATION
			3	3.01	3.02	4	5	6a.00
		GENERAL SERVICE COST						
003		NEW CAP REL COSTS-BLD	62,453					
003	01	NEW CAP REL COSTS-BLD		3,154				
003	02	NEW CAP REL COSTS-BLD			1,642			
004		NEW CAP REL COSTS-MVB				67,249		
005		EMPLOYEE BENEFITS	543			543	7,183,325	
006		ADMINISTRATIVE & GENE	10,363			10,363	1,048,383	-2,696,329
008		OPERATION OF PLANT	11,864			11,864	243,812	
009		LAUNDRY & LINEN SERVI	1,560			1,560	58,365	
010		HOUSEKEEPING	571			571	233,850	
011		DIETARY	1,690			1,690	137,515	
012		CAFETERIA	818			818	102,997	
014		NURSING ADMINISTRATIO	664			664	437,054	
017		MEDICAL RECORDS & LIB	1,479		192	1,671	189,442	
018		SOCIAL SERVICE					135,641	
		INPAT ROUTINE SRVC CN						
025		ADULTS & PEDIATRICS	10,077			10,077	898,637	
026		INTENSIVE CARE UNIT	1,799			1,799	501,243	
		ANCILLARY SRVC COST C						
037		OPERATING ROOM	6,607			6,607	219,963	
041		RADIOLOGY-DIAGNOSTIC	4,270			4,270	472,073	
044		LABORATORY	1,387			1,387	391,682	
049		RESPIRATORY THERAPY	903			903	272,153	
050		PHYSICAL THERAPY	2,020			2,020	364,932	
053		ELECTROCARDIOLOGY			1,450	1,450	114,840	
055		MEDICAL SUPPLIES CHAR					58,491	
056		DRUGS CHARGED TO PATI	601			601	155,397	
		OUTPAT SERVICE COST C						
061		EMERGENCY	2,596			2,596	457,229	
062		OBSERVATION BEDS (NON						
063		OTHER OUTPATIENT SERV						
063	50	RURAL HEALTH CLINIC	2,521			2,521	151,082	
		OTHER REIMBURS COST C						
065		AMBULANCE SERVICES		3,154		3,154	487,690	
		SPEC PURPOSE COST CEN						
095		SUBTOTALS	62,333	3,154	1,642	67,129	7,132,471	-2,696,329
		NONREIMBURS COST CENT						
096		GIFT, FLOWER, COFFEE	120			120		
098		PHYSICIANS' PRIVATE O					50,854	
098	01	PROMOTION						
099		NONPAID WORKERS						
101		CROSS FOOT ADJUSTMENT						
102		NEGATIVE COST CENTER						
103		COST TO BE ALLOCATED	182,015	26,000	15,459	1,012,783	2,623,408	
		(WRKSHT B, PART I)						
104		UNIT COST MULTIPLIER	2.914432		9.414738		.365208	
		(WRKSHT B, PT I)		8.243500		15.060194		
105		COST TO BE ALLOCATED						
		(WRKSHT B, PART II)						
106		UNIT COST MULTIPLIER						
		(WRKSHT B, PT II)						
107		COST TO BE ALLOCATED					9,761	
		(WRKSHT B, PART III						
108		UNIT COST MULTIPLIER					.001359	
		(WRKSHT B, PT III)						

	COST CENTER DESCRIPTION	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION
		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	(TIME SPENT)	(MEALS SERVED)	(FTE)	(NURSING FTES)
		6	8	9	10	11	12	14
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
003 01	NEW CAP REL COSTS-BLD							
003 02	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE	12,911,631						
008	OPERATION OF PLANT	1,062,184	39,875					
009	LAUNDRY & LINEN SERVI	138,419	1,560	168,106				
010	HOUSEKEEPING	382,768	571		95,053			
011	DIETARY	305,342	1,690	532	3,440	31,144		
012	CAFETERIA	157,241	818		4,015		10,786	
014	NURSING ADMINISTRATIO	625,701	664				765	87,328
017	MEDICAL RECORDS & LIB	312,808	1,671		955		591	
018	SOCIAL SERVICE	197,507					208	
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	1,513,474	10,077	113,729	31,775	27,544	2,367	39,416
026	INTENSIVE CARE UNIT	727,819	1,799	3,255	7,695	1,383	995	20,674
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	573,465	6,607	7,821	3,385		488	4,756
041	RADIOLOGY-DIAGNOSTIC	1,189,159	4,270	3,410	6,558		1,005	
044	LABORATORY	1,096,780	1,387		5,990		1,013	
049	RESPIRATORY THERAPY	468,588	903	2,752	4,135		665	
050	PHYSICAL THERAPY	517,101	2,020	3,244	2,000		567	
053	ELECTROCARDIOLOGY	261,919		4,410	3,630		222	2,549
055	MEDICAL SUPPLIES CHAR	181,035					205	
056	DRUGS CHARGED TO PATI	624,831	601		690		318	
	OUTPAT SERVICE COST C							
061	EMERGENCY	1,319,314	2,596	26,563	11,555		929	17,653
062	OBSERVATION BEDS (NON							
063	OTHER OUTPATIENT SERV							
063 50	RURAL HEALTH CLINIC	330,387	2,521	1,182	5,515		307	2,280
	OTHER REIMBURS COST C							
065	AMBULANCE SERVICES	789,557						
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	12,775,399	39,755	166,898	91,338	28,927	10,645	87,328
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE	2,157	120					
098	PHYSICIANS' PRIVATE O	134,075		1,208	3,715	2,217	141	
098 01	PROMOTION							
099	NONPAID WORKERS							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	2,696,329	1,283,999	217,558	481,088	441,624	236,738	794,538
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	.208829	32.200602	1.294172	5.061261	14.180067	21.948637	9.098319
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	187,697	229,022	39,092	19,425	45,537	22,648	27,045
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.014537	5.743498	.232544	.204360	1.462144	2.099759	.309694

		COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)
			17	18
		GENERAL SERVICE COST		
003		NEW CAP REL COSTS-BLD		
003	01	NEW CAP REL COSTS-BLD		
003	02	NEW CAP REL COSTS-BLD		
004		NEW CAP REL COSTS-MVB		
005		EMPLOYEE BENEFITS		
006		ADMINISTRATIVE & GENE		
008		OPERATION OF PLANT		
009		LAUNDRY & LINEN SERVI		
010		HOUSEKEEPING		
011		DIETARY		
012		CAFETERIA		
014		NURSING ADMINISTRATIO		
017		MEDICAL RECORDS & LIB	1,357	
018		SOCIAL SERVICE		317
		INPAT ROUTINE SRVC CN		
025		ADULTS & PEDIATRICS	585	278
026		INTENSIVE CARE UNIT	77	37
		ANCILLARY SRVC COST C		
037		OPERATING ROOM	49	
041		RADIOLOGY-DIAGNOSTIC		
044		LABORATORY	156	
049		RESPIRATORY THERAPY	156	
050		PHYSICAL THERAPY		
053		ELECTROCARDIOLOGY		
055		MEDICAL SUPPLIES CHAR		
056		DRUGS CHARGED TO PATI		
		OUTPAT SERVICE COST C		
061		EMERGENCY	330	2
062		OBSERVATION BEDS (NON		
063		OTHER OUTPATIENT SERV		
063	50	RURAL HEALTH CLINIC		
		OTHER REIMBURS COST C		
065		AMBULANCE SERVICES		
		SPEC PURPOSE COST CEN		
095		SUBTOTALS	1,353	317
		NONREIMBURS COST CENT		
096		GIFT, FLOWER, COFFEE		
098		PHYSICIANS' PRIVATE O	4	
098	01	PROMOTION		
099		NONPAID WORKERS		
101		CROSS FOOT ADJUSTMENT		
102		NEGATIVE COST CENTER		
103		COST TO BE ALLOCATED (PER WRKSHT B, PART	449,744	243,317
104		UNIT COST MULTIPLIER (WRKSHT B, PT I)	331.425203	767.561514
105		COST TO BE ALLOCATED (PER WRKSHT B, PART		
106		UNIT COST MULTIPLIER (WRKSHT B, PT II)		
107		COST TO BE ALLOCATED (PER WRKSHT B, PART	47,121	3,492
108		UNIT COST MULTIPLIER (WRKSHT B, PT III)	34.724392	11.015773

	DESCRIPTION	WORKSHEET PART	LINE NO.	AMOUNT
	1	2	3	4
1	ADJ FOR EPO COSTS IN RENAL DIA	1	57	
2	ADJ FOR EPO COSTS IN HOME PROG	1	64	
3	BLOOD ADMINISTRATION	1	61	-250
4		1	37	-876
5		1	25	-9,892
6		1	44	11,018

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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,660,550		3,660,550		
26	INTENSIVE CARE UNIT	1,264,366		1,264,366		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,002,571		1,002,571		
41	RADIOLOGY-DIAGNOSTIC	1,634,650		1,634,650		
44	LABORATORY	1,485,752		1,485,752		
49	RESPIRATORY THERAPY	686,308		686,308		
50	PHYSICAL THERAPY	716,898		716,898		
53	ELECTROCARDIOLOGY	368,759		368,759		
55	MEDICAL SUPPLIES CHARGED	223,339		223,339		
56	DRUGS CHARGED TO PATIENTS	785,139		785,139		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,062,936		2,062,936		
62	OBSERVATION BEDS (NON-DIS	302,689		302,689		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	537,484		537,484		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	954,439		954,439		
101	SUBTOTAL	15,685,880		15,685,880		
102	LESS OBSERVATION BEDS	302,689		302,689		
103	TOTAL	15,383,191		15,383,191		

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
	INPAT ROUTINE SRVC CNTRS						
25	ADULTS & PEDIATRICS	2,477,070		2,477,070			
26	INTENSIVE CARE UNIT	461,000		461,000			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	93,426	2,438,082	2,531,508	.396037	.396037	
41	RADIOLOGY-DIAGNOSTIC	1,279,700	9,348,659	10,628,359	.153801	.153801	
44	LABORATORY	1,802,845	4,998,775	6,801,620	.218441	.218441	
49	RESPIRATORY THERAPY	414,745	318,903	733,648	.935473	.935473	
50	PHYSICAL THERAPY	217,750	707,719	925,469	.774632	.774632	
53	ELECTROCARDIOLOGY	377,660	1,074,210	1,451,870	.253989	.253989	
55	MEDICAL SUPPLIES CHARGED	55,453	113,762	169,215	1.319853	1.319853	
56	DRUGS CHARGED TO PATIENTS	1,725,792	819,829	2,545,621	.308427	.308427	
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	57,264	2,323,140	2,380,404	.866633	.866633	
62	OBSERVATION BEDS (NON-DIS	10,974	200,085	211,059	1.434144	1.434144	
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC		309,119	309,119	1.738761	1.738761	
	OTHER REIMBURS COST CNTRS						
65	AMBULANCE SERVICES	59,862	1,543,789	1,603,651	.595166	.595166	
101	SUBTOTAL	9,033,541	24,196,072	33,229,613			
102	LESS OBSERVATION BEDS						
103	TOTAL	9,033,541	24,196,072	33,229,613			

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
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	3,660,550		3,660,550		
26	INTENSIVE CARE UNIT	1,264,366		1,264,366		
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,002,571		1,002,571		
41	RADIOLOGY-DIAGNOSTIC	1,634,650		1,634,650		
44	LABORATORY	1,485,752		1,485,752		
49	RESPIRATORY THERAPY	686,308		686,308		
50	PHYSICAL THERAPY	716,898		716,898		
53	ELECTROCARDIOLOGY	368,759		368,759		
55	MEDICAL SUPPLIES CHARGED	223,339		223,339		
56	DRUGS CHARGED TO PATIENTS	785,139		785,139		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,062,936		2,062,936		
62	OBSERVATION BEDS (NON-DIS	302,689		302,689		
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	537,484		537,484		
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	954,439		954,439		
101	SUBTOTAL	15,685,880		15,685,880		
102	LESS OBSERVATION BEDS	302,689		302,689		
103	TOTAL	15,383,191		15,383,191		

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

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
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,477,070		2,477,070			
26		INTENSIVE CARE UNIT	461,000		461,000			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	93,426	2,438,082	2,531,508	.396037	.396037	
41		RADIOLOGY-DIAGNOSTIC	1,279,700	9,348,659	10,628,359	.153801	.153801	
44		LABORATORY	1,802,845	4,998,775	6,801,620	.218441	.218441	
49		RESPIRATORY THERAPY	414,745	318,903	733,648	.935473	.935473	
50		PHYSICAL THERAPY	217,750	707,719	925,469	.774632	.774632	
53		ELECTROCARDIOLOGY	377,660	1,074,210	1,451,870	.253989	.253989	
55		MEDICAL SUPPLIES CHARGED	55,453	113,762	169,215	1.319853	1.319853	
56		DRUGS CHARGED TO PATIENTS	1,725,792	819,829	2,545,621	.308427	.308427	
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	57,264	2,323,140	2,380,404	.866633	.866633	
62		OBSERVATION BEDS (NON-DIS	10,974	200,085	211,059	1.434144	1.434144	
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		309,119	309,119	1.738761	1.738761	
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	59,862	1,543,789	1,603,651	.595166	.595166	
101		SUBTOTAL	9,033,541	24,196,072	33,229,613			
102		LESS OBSERVATION BEDS						
103		TOTAL	9,033,541	24,196,072	33,229,613			

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
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,002,571	172,051	830,520			1,002,571
41		RADIOLOGY-DIAGNOSTIC	1,634,650	123,449	1,511,201			1,634,650
44		LABORATORY	1,485,752	58,140	1,427,612			1,485,752
49		RESPIRATORY THERAPY	686,308	36,897	649,411			686,308
50		PHYSICAL THERAPY	716,898	58,278	658,620			716,898
53		ELECTROCARDIOLOGY	368,759	42,475	326,284			368,759
55		MEDICAL SUPPLIES CHARGED	223,339	3,141	220,198			223,339
56		DRUGS CHARGED TO PATIENTS	785,139	24,358	760,781			785,139
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	2,062,936	108,809	1,954,127			2,062,936
62		OBSERVATION BEDS (NON-DIS	302,689		302,689			302,689
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	537,484	67,554	469,930			537,484
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	954,439	85,641	868,798			954,439
101		SUBTOTAL	10,760,964	780,793	9,980,171			10,760,964
102		LESS OBSERVATION BEDS	302,689		302,689			302,689
103		TOTAL	10,458,275	780,793	9,677,482			10,458,275

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	2,531,508	.396037	.396037
41		RADIOLOGY-DIAGNOSTIC	10,628,359	.153801	.153801
44		LABORATORY	6,801,620	.218441	.218441
49		RESPIRATORY THERAPY	733,648	.935473	.935473
50		PHYSICAL THERAPY	925,469	.774632	.774632
53		ELECTROCARDIOLOGY	1,451,870	.253989	.253989
55		MEDICAL SUPPLIES CHARGED	169,215	1.319853	1.319853
56		DRUGS CHARGED TO PATIENTS	2,545,621	.308427	.308427
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	2,380,404	.866633	.866633
62		OBSERVATION BEDS (NON-DIS	211,059	1.434144	1.434144
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	309,119	1.738761	1.738761
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES	1,603,651	.595166	.595166
101		SUBTOTAL	30,291,543		
102		LESS OBSERVATION BEDS	211,059		
103		TOTAL	30,080,484		

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
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,002,571	172,051	830,520			1,002,571
41		RADIOLOGY-DIAGNOSTIC	1,634,650	123,449	1,511,201			1,634,650
44		LABORATORY	1,485,752	58,140	1,427,612			1,485,752
49		RESPIRATORY THERAPY	686,308	36,897	649,411			686,308
50		PHYSICAL THERAPY	716,898	58,278	658,620			716,898
53		ELECTROCARDIOLOGY	368,759	42,475	326,284			368,759
55		MEDICAL SUPPLIES CHARGED	223,339	3,141	220,198			223,339
56		DRUGS CHARGED TO PATIENTS	785,139	24,358	760,781			785,139
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	2,062,936	108,809	1,954,127			2,062,936
62		OBSERVATION BEDS (NON-DIS	302,689		302,689			302,689
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	537,484	67,554	469,930			537,484
		OTHER REIMBURS COST CNTRS						
65		AMBULANCE SERVICES	954,439	85,641	868,798			954,439
101		SUBTOTAL	10,760,964	780,793	9,980,171			10,760,964
102		LESS OBSERVATION BEDS	302,689		302,689			302,689
103		TOTAL	10,458,275	780,793	9,677,482			10,458,275

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1323 I PERIOD: I FROM 4/ 1/2007 I TO 3/31/2008 I PREPARED 8/15/2008 WORKSHEET C PART II

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	2,531,508	.396037	.396037
41	RADIOLOGY-DIAGNOSTIC	10,628,359	.153801	.153801
44	LABORATORY	6,801,620	.218441	.218441
49	RESPIRATORY THERAPY	733,648	.935473	.935473
50	PHYSICAL THERAPY	925,469	.774632	.774632
53	ELECTROCARDIOLOGY	1,451,870	.253989	.253989
55	MEDICAL SUPPLIES CHARGED	169,215	1.319853	1.319853
56	DRUGS CHARGED TO PATIENTS	2,545,621	.308427	.308427
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	2,380,404	.866633	.866633
62	OBSERVATION BEDS (NON-DIS	211,059	1.434144	1.434144
63	OTHER OUTPATIENT SERVICE			
63 50	RURAL HEALTH CLINIC	309,119	1.738761	1.738761
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES	1,603,651	.595166	.595166
101	SUBTOTAL	30,291,543		
102	LESS OBSERVATION BEDS	211,059		
103	TOTAL	30,080,484		

TITLE XVIII, PART B HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
	Cost Center Description	1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.396037		.396037		
41	RADIOLOGY-DIAGNOSTIC	.153801		.153801		
44	LABORATORY	.218441		.218441		
49	RESPIRATORY THERAPY	.935473		.935473		
50	PHYSICAL THERAPY	.774632		.774632		
53	ELECTROCARDIOLOGY	.253989		.253989		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.319853		1.319853		
56	DRUGS CHARGED TO PATIENTS	.308427		.308427		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.866633		.866633		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.434144		1.434144		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES	.595166		.595166		
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

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

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic 4	All Other (1) 5	Outpatient Ambulatory Surgical Ctr 6	Outpatient Radialogy 7	Other Outpatient Diagnostic 8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		1,210,039			
41	RADIOLOGY-DIAGNOSTIC		3,236,158			
44	LABORATORY		1,718,081			
49	RESPIRATORY THERAPY		144,027			
50	PHYSICAL THERAPY		207,319			
53	ELECTROCARDIOLOGY		427,505			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		63,932			
56	DRUGS CHARGED TO PATIENTS		431,162			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		647,020			
62	OBSERVATION BEDS (NON-DISTINCT PART)		113,630			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
	OTHER REIMBURS COST CNTRS					
65	AMBULANCE SERVICES					
101	SUBTOTAL		8,198,873			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		8,198,873			

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

TITLE XVIII, PART B HOSPITAL

		Cost Center Description	All Other 9	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
(A)		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	479,220		
41		RADIOLOGY-DIAGNOSTIC	497,724		
44		LABORATORY	375,299		
49		RESPIRATORY THERAPY	134,733		
50		PHYSICAL THERAPY	160,596		
53		ELECTROCARDIOLOGY	108,582		
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	84,381		
56		DRUGS CHARGED TO PATIENTS	132,982		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	560,729		
62		OBSERVATION BEDS (NON-DISTINCT PART)	162,962		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		SUBTOTAL	2,697,208		
102		CRNA CHARGES			
103		LESS PBP CLINIC LAB SVCS- PROGRAM ONLY CHARGES			
104		NET CHARGES	2,697,208		

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

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

Line	Description	1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,910
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,891
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,891
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	723
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)	268
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	21
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)	7
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,739
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	723
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)	263
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	100.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,660,550
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	2,100
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	700
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	745,287
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,915,263
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,157,415
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,157,415
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.351276
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	554.46
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	2,915,263

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	749.23
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,052,141
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2,052,141

		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	1,264,366	461	2,742.66	337	924,276
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,168,764
49	TOTAL PROGRAM INPATIENT COSTS	4,145,181
	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)	541,693
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	197,047
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	738,740
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	404
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	749.23
85	OBSERVATION BED COST	302,689

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,910
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,891
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,891
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	723
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)	268
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	21
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)	7
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	223
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	100.00
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,660,550
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	2,100
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	700
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	745,287
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,915,263
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,157,415
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,157,415
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.351276
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	554.46
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	2,915,263

TITLE XIX - I/P HOSPITAL OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

						1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					749.23
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					167,078
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					167,078
		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	1,264,366	461	2,742.66	20	54,853
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					
49	TOTAL PROGRAM INPATIENT COSTS					221,931
	PASS THROUGH COST ADJUSTMENTS					
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES					
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES					
52	TOTAL PROGRAM EXCLUDABLE COST					
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS					
	TARGET AMOUNT AND LIMIT COMPUTATION					
54	PROGRAM DISCHARGES					
55	TARGET AMOUNT PER DISCHARGE					
56	TARGET AMOUNT					
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT					
58	BONUS PAYMENT					
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET					
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.					
58.04	RELIEF PAYMENT					
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT					
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)					
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1					
59.03	PROGRAM DISCHARGES AFTER JULY 1					
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)					
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)					
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)					
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					
	PROGRAM INPATIENT ROUTINE SWING BED COST					
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)					
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS					
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD					
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD					
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS					

TITLE XIX - I/P HOSPITAL OTHER

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

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

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	404
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	749.23
85	OBSERVATION BED COST	302,689

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1323 I PERIOD: FROM 4/ 1/2007 TO 3/31/2008 I PREPARED 8/15/2008
I COMPONENT NO: 14-1323 I WORKSHEET D-4

TITLE XVIII, PART A HOSPITAL OTHER

WKST A LINE NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		1,646,790	
26		INTENSIVE CARE UNIT		337,000	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.396037	80,079	31,714
41		RADIOLOGY-DIAGNOSTIC	.153801	759,220	116,769
44		LABORATORY	.218441	1,142,457	249,559
49		RESPIRATORY THERAPY	.935473	286,239	267,769
50		PHYSICAL THERAPY	.774632	65,939	51,078
53		ELECTROCARDIOLOGY	.253989	240,448	61,071
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	1.319853	25,149	33,193
56		DRUGS CHARGED TO PATIENTS	.308427	1,107,313	341,525
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	.866633	18,562	16,086
62		OBSERVATION BEDS (NON-DISTINCT PART)	1.434144		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC			
		OTHER REIMBURS COST CNTRS			
65		AMBULANCE SERVICES			
101		TOTAL		3,725,406	1,168,764
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		3,725,406	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO: 14-1323 | COMPONENT NO: 14-Z323 | PERIOD: FROM 4/ 1/2007 TO 3/31/2008 | PREPARED 8/15/2008 | WORKSHEET D-4

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
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.396037	10,532	4,171
41	RADIOLOGY-DIAGNOSTIC	.153801	70,271	10,808
44	LABORATORY	.218441	214,956	46,955
49	RESPIRATORY THERAPY	.935473	38,449	35,968
50	PHYSICAL THERAPY	.774632	146,141	113,205
53	ELECTROCARDIOLOGY	.253989	7,339	1,864
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.319853	2,358	3,112
56	DRUGS CHARGED TO PATIENTS	.308427	275,397	84,940
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.866633	5,158	4,470
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.434144		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
65	AMBULANCE SERVICES			
101	TOTAL		770,601	305,493
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		770,601	

PART B - MEDICAL AND OTHER HEALTH SERVICES

Line	Description	HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	2,697,208
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)	2,697,208
	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)	2,724,180
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	35,977
18.01	CAH ACTUAL BILLED COINSURANCE	1,277,098
	LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	1,411,105
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	1,411,105
24	PRIMARY PAYER PAYMENTS	374
25	SUBTOTAL	1,410,731
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	554,167
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	554,167
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	1,964,898
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	1,964,898
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	1,379,997
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	584,901
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

PROVIDER NO: 14-1323	PERIOD: FROM 4/ 1/2007 TO 3/31/2008	PREPARED 8/15/2008 WORKSHEET E-1
COMPONENT NO: 14-1323		

TITLE XVIII HOSPITAL

DESCRIPTION			INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER				3,583,241		1,321,575
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	10/ 5/2007	102,443	3/31/2008	123,816
	ADJUSTMENTS TO PROVIDER	.02	10/ 5/2007	16,274	3/31/2008	38,148
	ADJUSTMENTS TO PROVIDER	.03	3/31/2008	43,120		
	ADJUSTMENTS TO PROVIDER	.04	3/31/2008	52,404		
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50			10/ 5/2007	31,920
	ADJUSTMENTS TO PROGRAM	.51			10/ 5/2007	71,622
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
SUBTOTAL		.99		214,241		58,422
4 TOTAL INTERIM PAYMENTS				3,797,482		1,379,997
TO BE COMPLETED BY INTERMEDIARY						
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)						
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
SUBTOTAL		.99		NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01				
	SETTLEMENT TO PROGRAM	.02				
7 TOTAL MEDICARE PROGRAM LIABILITY						

NAME OF INTERMEDIARY:
INTERMEDIARY NO: 00000

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

PROVIDER NO:	PERIOD:	PREPARED 8/15/2008
14-1323	FROM 4/ 1/2007	WORKSHEET E-1
COMPONENT NO:	TO 3/31/2008	
14-Z323		

TITLE XVIII SWING BED SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			1,041,811		
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	10/ 5/2007	19,673		
	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		19,673		NONE
4	TOTAL INTERIM PAYMENTS			1,061,484		
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1) — SETTLEMENT TO PROVIDER	.01				
	SETTLEMENT TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY					

NAME OF INTERMEDIARY:
INTERMEDIARY NO: 00000

SIGNATURE OF AUTHORIZED PERSON: ____

DATE: ___/___/___

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

TITLE XVIII SWING BED SNF

	COMPUTATION OF NET COST OF COVERED SERVICES	PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	746,127	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	308,548	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	986	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	1,054,675	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	1,054,675	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	1,054,675	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	16,808	
14	80% OF PART B COSTS		
15	SUBTOTAL	1,037,867	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS	476	
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	1,038,343	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	1,061,484	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	-23,141	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

Line	Description	HOSPITAL
1	INPATIENT SERVICES	4,145,181
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	4,145,181
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	4,186,633
	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	4,186,633
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	463,674
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,722,959
23	COINSURANCE	11,160
24	SUBTOTAL	3,711,799
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	118,538
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	118,538
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,830,337
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	3,830,337
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,797,482
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	32,855
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

	ASSETS	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	4,698,213			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	5,561,328			
5	OTHER RECEIVABLES	906,181			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,895,000			
7	INVENTORY	266,698			
8	PREPAID EXPENSES	294,168			
9	OTHER CURRENT ASSETS	880,204			
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	8,711,792			
	FIXED ASSETS				
12	LAND	13,981			
12.01					
13	LAND IMPROVEMENTS	173,980			
13.01	LESS ACCUMULATED DEPRECIATION	-151,130			
14	BUILDINGS	16,212,739			
14.01	LESS ACCUMULATED DEPRECIATION	-5,313,572			
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	6,834,121			
18.01	LESS ACCUMULATED DEPRECIATION	-5,186,026			
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	12,584,093			
	OTHER ASSETS				
22	INVESTMENTS	4,960,436			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS				
25	OTHER ASSETS	434,876			
26	TOTAL OTHER ASSETS	5,395,312			
27	TOTAL ASSETS	26,691,197			

	LIABILITIES AND FUND BALANCE	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	969,749			
29	SALARIES, WAGES & FEES PAYABLE	720,780			
30	PAYROLL TAXES PAYABLE	458,681			
31	NOTES AND LOANS PAYABLE (SHORT TERM)	568,420			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	223,002			
36	TOTAL CURRENT LIABILITIES	2,940,632			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	13,220,432			
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	13,220,432			
43	TOTAL LIABILITIES	16,161,064			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	10,530,133			
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	10,530,133			
52	TOTAL LIABILITIES AND FUND BALANCES	26,691,197			

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		9,125,810		
2	NET INCOME (LOSS)		1,404,323		
3	TOTAL		10,530,133		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4					
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		10,530,133		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12					
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		10,530,133		

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

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	2,157,415		2,157,415
4	00	SWING BED - SNF	407,970		407,970
5	00	SWING BED - NF			
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	2,565,385		2,565,385
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10	00	INTENSIVE CARE UNIT	461,000		461,000
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP	461,000		461,000
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	3,026,385		3,026,385
17	00	ANCILLARY SERVICES	6,080,400	24,608,127	30,688,527
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		309,119	309,119
20	00	AMBULANCE SERVICES	59,862	1,543,789	1,603,651
24	00				
25	00	TOTAL PATIENT REVENUES	9,166,647	26,461,035	35,627,682

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		16,925,131
		ADD (SPECIFY)		
27	00	BAD DEBT EXPENSE	1,991,258	
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		1,991,258
		DEDUCT (SPECIFY)		
34	00			
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		18,916,389

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	35,627,682
2	LESS: ALLOWANCES AND DISCOUNTS ON	15,860,938
3	NET PATIENT REVENUES	19,766,744
4	LESS: TOTAL OPERATING EXPENSES	18,916,389
5	NET INCOME FROM SERVICE TO PATIENT	850,355
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	196,699
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	20,193
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	64,295
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	3,215
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	16,537
23	GOVERNMENTAL APPROPRIATIONS	177,426
24	GRANTS AND GIFTS	36,955
24.01	EDUCATION SERVICES	14,305
24.02	OTHER MISCELLANEOUS INCOME	25,787
25	TOTAL OTHER INCOME	555,412
26	TOTAL	1,405,767
	OTHER EXPENSES	
27		
28	LOSS ON DISPOSAL OF CAPITAL ASSETS	1,444
29		
30	TOTAL OTHER EXPENSES	1,444
31	NET INCOME (OR LOSS) FOR THE PERIO	1,404,323

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI-CATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN				
2	PHYSICIAN ASSISTANT	94,412		94,412	
3	NURSE PRACTITIONER				
4	VISITING NURSE				
5	OTHER NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	94,412		94,412	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT		44,375	44,375	
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)		44,375	44,375	
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES		10,007	10,007	
16	TRANSPORTATION (HEALTH CARE STAFF)		1,524	1,524	
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)		11,531	11,531	
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	94,412	55,906	150,318	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	56,670	16,098	72,768	6,811
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	56,670	16,098	72,768	6,811
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	151,082	72,004	223,086	6,811

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN			
2	PHYSICIAN ASSISTANT	94,412		94,412
3	NURSE PRACTITIONER			
4	VISITING NURSE			
5	OTHER NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	94,412		94,412
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT	44,375		44,375
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)	44,375		44,375
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES	10,007		10,007
16	TRANSPORTATION (HEALTH CARE STAFF)	1,524		1,524
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)	11,531		11,531
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	150,318		150,318
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	79,579		79,579
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	79,579		79,579
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	229,897		229,897

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS			4,200	
2	PHYSICIAN ASSISTANTS	1.10	4,102	2,100	2,310
3	NURSE PRACTITIONERS			2,100	
4	SUBTOTAL (SUM OF LINES 1-3)	1.10	4,102		2,310
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	1.10	4,102		
9	PHYSICIAN SERVICES UNDER AGREEMENTS		219		

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES	
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	150,318
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)	150,318
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)	79,579
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	307,587
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	387,166
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	387,166
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	387,166
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	537,484

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	4,102
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTES AND VISITS (SUM OF LINES 4-7)	4,102
9	PHYSICIAN SERVICES UNDER AGREEMENTS	219

(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

PROVIDER NO:	PERIOD:	PREPARED 8/15/2008
14-1323	FROM 4/ 1/2007	WORKSHEET M-3
COMPONENT NO:	TO 3/31/2008	
14-3478		

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	537,484	
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	179	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	537,305	
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	4,102	
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	219	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,321	
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	124.35	
		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1
		1	2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	74.29	76.52
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	124.35	124.35
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		369
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		45,885
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)*		45,885
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		2,788
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		43,097
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		34,478
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		90
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		34,568
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		764
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)		35,332
25	INTERIM PAYMENTS		35,744
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-412
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

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

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER NO: 14-1323	PERIOD: FROM 4/ 1/2007 TO 3/31/2008	PREPARED 8/15/2008 WORKSHEET M-4
	COMPONENT NO: 14-3478		

TITLE XVIII RHC 1

		PNEUMOCOCCAL 1	INFLUENZA 2
1	HEALTH CARE STAFF COST (FROM WORKSHEET M-1, COLUMN 7, LINE 10)	94,412	94,412
2	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME		.000097
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 X LINE 2)		9
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (FROM YOUR RECORDS)		41
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)		50
6	TOTAL DIRECT COST OF THE FACILITY (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	150,318	150,318
7	TOTAL OVERHEAD (FROM WORKSHEET M-2, LINE 16)	387,166	387,166
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)		.000333
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 X LINE 8)		129
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION (SUM OF LINES 5 AND 9)		179
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)		4
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 DIVIDED BY LINE 11)		44.75
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		2
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (LINE 12 X LINE 13)		90
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 10)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 2)		179
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION (SUM OF COLUMNS 1 AND 2, LINE 14)(TRANSFER THIS AMOUNT TO WORKSHEET M-3, LINE 20)		90

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

PROVIDER NO: 14-1323 | COMPONENT NO: 14-3478 | PERIOD: FROM 4/ 1/2007 TO 3/31/2008 | PREPARED 8/15/2008 | WORKSHEET M-5

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			35,070
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01	10/ 5/2007	674
	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		674
4	TOTAL INTERIM PAYMENTS			35,744
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1) — SETTLEMENT TO PROVIDER	.01		
	SETTLEMENT TO PROGRAM	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY			

NAME OF INTERMEDIARY:
INTERMEDIARY NO: 00000

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.